

107

VIOLENCE AS A PUBLIC HEALTH ISSUE

Y 4.G 74/7:V 81/3

Violence as a Public Health Issue,...

HEARING
BEFORE THE
HUMAN RESOURCES AND INTERGOVERNMENTAL
RELATIONS SUBCOMMITTEE
OF THE
COMMITTEE ON
GOVERNMENT OPERATIONS
HOUSE OF REPRESENTATIVES
ONE HUNDRED THIRD CONGRESS
FIRST SESSION

NOVEMBER 1, 1993

Printed for the use of the Committee on Government Operations



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VIOLENCE AS A PUBLIC HEALTH ISSUE

MONDAY, NOVEMBER 1, 1993

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:45 a.m., in room 2154, Rayburn House Office Building, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Edolphus Towns and Donald M. Payne.

Also present: Brenda E. Pillors, professional staff member, Martine M. DiCrocce, clerk; and Martha B. Morgan, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN TOWNS

Mr. TOWNS. The Committee on Government Operations Subcommittee on Human Resources and Intergovernmental Relations hearing will come to order.

The hearing today is on violence as a public health issue. We will continue the subcommittee's series of hearings on issues related to health care reform.

Our society is self-destructing as a consequence of violence that engulfs families, neighborhoods, and communities. Many Americans are paralyzed with fear about the prospect of becoming a victim of violence or having to live or work in close proximity to potential violence.

Violence has moved from an issue solely within the criminal justice system to the health care arena. This change is largely due to the geometric increase in deaths and injuries due to gun violence.

Nowhere is this situation more evident than with America's youth. The Federal Centers for Disease Control and Prevention reports that firearms have accounted for more than 90 percent of the upturn in homicides in young Americans since the mid-1980's. A recent Washington Post article reported that guns kill more teenagers than cancer, heart disease, AIDS, and other diseases combined. In some States, teenagers are even more likely to die from a bullet than they are from a traffic accident.

For black youth, the statistics are even more shocking. The homicide rate among black men aged 15 to 24 rose by 66 percent during the 1980's; 95 percent of the increase was a direct result of violence.

Gun sales are spiraling as evidenced by the number of Americans arming themselves against an anticipated but unknown assailant.

But violence is not limited to guns. Throughout our Nation there are numerous examples of elderly in nursing homes and children in hospitals whose circumstances warrant attention but whose voices and complaints go unheeded.

Just this past week, the President declared the month of October for 1993 and 1994 to be National Domestic Violence Awareness Month. Domestic violence is more than the occasional family dispute. According to the Department of Health and Human Services, it is the single largest cause of injury to American women, affecting 6 million of all racial, cultural, and economic backgrounds.

The cost of violence is not only in human lives but there is also a cost in real dollars and cents. As President Clinton stated recently, "Violence crowds our emergency rooms and drains our medical resources." Victims of violence almost always end up in the Nation's emergency rooms. And I can tell you as a former health care administrator that receiving care in an emergency room setting is probably the most expensive form of health care available today.

Today's hearing will explore not just the problems of violence but how it impacts the daily lives of ordinary American citizens. We will hear from the actual victims of violence about the impact of violence on their lives and how it has changed them. We will also hear from researchers and health care providers who are concerned about the additional socioeconomic costs to society and the burden on the health care delivery system.

Finally, the subcommittee plans additional hearings on this topic next year when the President announces his antiviolenence strategy.

Today, we are honored to have the top public health officer in the Nation to discuss with us the administration's focus and plans for addressing the prevention of violence. But before moving forward and hearing from our Surgeon General, Dr. Joycelyn Elders, I would like to recognize my colleague from the State of New Jersey, who is a person that has been very active on all these issues, and one that is very compassionate. She has said over and over again we must do something about the violence in our Nation. I now yield to Congressman Donald Payne from New Jersey.

Congressman Payne.

Mr. PAYNE. Thank you very much, Mr. Chairman. Let me first commend you for your leadership in calling this very important hearing this morning.

I would also like to commend Dr. Elders, the Surgeon General, for her commitment and leadership in bringing this issue to the forefront of our public health agenda.

Also, I look forward to hearing Congressman Louis Stokes, who last year called for the creation of a Select Committee on Violence and has held a number of meetings and hearings regarding the question of violence as a public health problem.

And I want to extend my regard to the panel of witnesses who have agreed to provide us with their testimony this morning, especially our young people who are the victims.

Violence is becoming an increasingly great public health threat in this country. Every one of us in this room today knows about the startling statistics regarding violence in our Nation. We all know that homicide is the No. 1 cause of death among African-American males aged 15 to 24, and is the leading cause of death

among black males and females between the ages of 15 and 24. Violence is so well integrated into our culture that every 6 minutes an act of violence is depicted on television.

Such statistics are evidence of the threat of violence in our society. But what about the threat to our public health? More than 1 million women are impacted each year by domestic violence, not to mention those who are assaulted by strangers. Rapes feed into the growing fear and threat of AIDS in this country.

Additionally, the cost of violent incidents to our Nation's trauma centers and hospital emergency rooms are fueling the escalating cost of our health care system. Violence incurs great physical and psychological consequences on our society.

The widespread nature of these consequences may indicate that violence has become a routine part of social interaction in our daily lives. As a result, it may also have become the adopted and accepted mode of behavior by current and future generations. We can see this in the increased number of violent acts committed by today's youth.

During the 1980's, youth between the ages of 12 and 24 committed more than 48,000 homicides, and nearly half of the 4.2 million nonfatal violent acts. Law enforcement efforts as a result of the epidemic numbers of rampant violence have been increased. However, these acts are merely the symptom of a larger problem, and until we as a Nation get ready to confront the real issues underscoring the nature of violence in this country, this very dangerous and unhealthy trend will continue.

I want to emphasize the importance of not letting our interests or our involvement stop at the conclusion of this forum. As we have heard the chairman say, this is just the beginning, and we will continue. It is imperative to the very survival of our community that we not be impeded by the size of the problem. We have to take steps to counteract the circumstances that erode our children's self-image and self-respect.

Again, Mr. Chairman, I would like to thank you for calling this hearing. Let me just finally draw attention to a front page article in the Washington Post today.

It says, "Getting ready to die young." And it talks about the fact that it is not uncommon for young children, 10, 11, 12, 13, to start to plan their funerals. They talk about the dresses that they want to wear. They talk about the songs they want to be played. They talk about how they want the flowers to be arranged and what they want their classmates to wear.

We must do something drastically to stop this insane trend.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Payne follows:]

Rep. Donald M. Payne (D-NJ)

Opening Statement
Hearing -- "Violence as a Public Health Issue"
November 1, 1993
2154 RHOB

Good Morning. I want to commend Chairman Towns for his leadership in calling this hearing today. I would also like to commend Dr. Elders, the Surgeon General for her commitment and leadership for bringing this issue to the forefront of our public health agenda. And, I want to extend my regards to the panel of witnesses who have agreed to provide us with their testimony this morning.

Violence is becoming an increasingly great public health threat in this country. Everyone of us in this room today knows about the startling statistics regarding violence in our nation. We all know that homicide is the number one cause of death among African American males ages 15-34 and it is the leading cause of death among black males and females, ages 15-24. Violence is so well integrated into our culture that every six minutes, an act of violence is depicted on T.V.

Such statements are evidence of the threat of violence in our society, but what about the threats to the public health? More than one million women are impacted each year by domestic violence, not to mention those who are assaulted by strangers. Rapes feed into the growing fear and threat of AIDS in this country. Additionally, the cost of violent incidents to the nation's trauma centers and hospital emergency rooms is fueling the escalating cost of our health care system.

Violence incurs great physical and psychological consequences on society. The widespread nature of these consequences may indicate that violence has become a routine part of social interaction in our daily lives. As a result, it may also have become the adopted and accepted mode of behavior by current and future generations.

We can see this in the increased number of violent acts committed by today's youth. During the 1980s, youth between the ages of 12 and 24 have committed more than 48,000 homicides and nearly half of 4.2 million nonfatal violent crimes.

Law enforcement efforts as a result of the epidemic numbers of rampant violence have been increased. However, these acts are merely the symptoms of a larger problem. And, until we as a nation are ready to confront the real issues underscoring the nature of violence in this country, this very dangerous and unhealthy trend will continue.

I want to emphasize the importance of not letting our interest or our involvement stop at the conclusion of this forum. It is imperative to the very survival of our community, that we not be impeded by the size of this problem. We have to take steps to counteract the circumstances that erode our children's self image and self respect.

Again, Mr. Chairman I would like to thank you for calling this hearing on this very important subject. Dr. Elders, let me just say I appreciate the time you have personally given us to discuss this very important subject and I look forward to hearing the testimony of our witnesses.

Mr. TOWNS. Thank you, Mr. Payne. I agree with you, that is a sad commentary, and we must do something about it.

At this time I would like to call on Dr. Elders, who is the U.S. Surgeon General, and to say to her that her entire statement will be included in the record. We are delighted to have you come to testify before this committee. Thank you very much.

**STATEMENT OF JOYCELYN ELDERS, M.D., SURGEON GENERAL,
PUBLIC HEALTH SERVICE, U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES**

Dr. ELDERS. Thank you, Congressman Towns.

Congressman Towns, other members of the Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Operations, I am Dr. Joycelyn Elders, your Surgeon General. I am a pediatrician, a mother, a teacher, and a citizen in a country and a city where violence has reached epidemic proportions.

You have asked me here today to talk about violence as a public health issue, particularly the health consequences of violence, our efforts at prevention and the implications for health care professionals and institutions.

We ordinarily think of violence as a crime. And it is. But it is also a public health problem, because it kills and injures so many of our people, especially our young people, and our children.

In 1987, there were over 20,000 homicides and 31,000 suicides in this country. That is over 50,000 deaths per year; 1 every 10 minutes, and 137 per day. It is greater than the deaths caused by AIDS, which is over 33,000 per year, 1 every 16 minutes, or 90 per day. It is greater than that caused by drunk driving, nearly 18,000 people per year, or 1 every 30 minutes, or 49 per day. Rape increased 21 percent from 1977 to 1984, and 20 percent of adult women have been physically abused at least once.

Second, violence must be considered a public health problem because the criminal justice approach is not enough. It treats the problem after it occurs. Our prisons are overcrowded, our courts are backlogged, and our police are overworked, and still our streets are not safe. We must couple prevention with our criminal justice system of treatment.

Finally, violence is a public health problem because it is a problem to be solved, and must not be considered a fact of life. Violence is preventable. It is a learned behavior. As your Surgeon General, I am about preventing problems before they happen.

Violence has public health consequences. In recent years, there has been an extraordinarily increased rate of both homicide and suicide among our young people, as both you and Mr. Payne have just stated.

Since the 1950's, suicide rates among our youth have almost quadrupled and homicide rates among young men are 20 times higher than most industrialized countries. And if we just look at our young black men, it is 40 times higher than in the next industrialized country.

As these rates have increased, the average age of both the perpetrators and the victims have fallen so that today we have a problem of children killing children. Today in America 14 children

under the age of 19 will die in suicides, homicides, or accidental shootings. Many more than that will be injured. Whereas we have over 20,000 deaths, we have over 2 million injuries secondary to violence.

Of all African-American teenagers who died in 1990, 57 percent were killed with guns. This is up from 48 percent in 1988. Children are killing children.

To me as your Surgeon General, this is totally unacceptable. If we are to have true security and health care reform, we must restore security in our homes, our schools, our streets, and our Nation. The cost to this country is too great to be ignored. The cost of firearm injuries alone to our health care system is nearly \$3 billion a year.

The total medical cost of all violence in the United States was \$13.5 billion in 1992. In the District of Columbia, our Nation's capital, the cost of criminal violence to hospitals totaled \$20.4 million in 1989, and we all know it is markedly increased today. The vast majority, 85 percent of the hospital cost for treatment of firearm injuries, were unreimbursed care.

In addition to the financial cost, the emotional and psychological costs are enormous. What causes violence, and what can we do to prevent it? Although many factors contribute to this epidemic, at its root it is poverty.

And one of the things that bothered me so much recently, that in 1970 we knew that 1 out of 7 of our children were poor. In 1990, it was 1 in 5. In 1992, just 2 years later, it was 1 in 4. In fact, 27 percent of all the children in America under 6 were poor. And then we looked at minority children. It is 1 in 2.

Related to the poverty are changing family structures. The plight of our inner cities. The difficulties in our schools. Other key factors are the availability of alcohol, drugs, and firearms to our children.

There are over 200 million firearms in this country, 67 million handguns, and over 1 million semiautomatic assault weapons. It is often easier for our children to obtain a gun than it is for them to find a good friend, a good teacher, a good school, or even a minister.

I already testified before this Congress on the role of the media. The entertainment industry can play a major role in impacting this problem by airing prosocial programs, by helping with public service announcements, by showing the emotional consequences of violence. And I feel that our media, the most powerful tool we have got to reach all of our people, must respond and help with this major problem.

Of more significance is the violence our children are exposed to in their homes, their communities, and on the streets. The newscast is very real to them. Too many of our children witness fighting among their parents. And unfortunately, too many see one parent beaten or murdered. These scars last a lifetime.

So what can we do to prevent this tragic health problem? One of the first things I feel we can and must do, we must take the tools of violence out of the hands of our children. And, Mr. Chairman, I feel that you can do much to help with that.

Second, we must incorporate violence prevention into our school curriculum. I am convinced that schools offer us the easiest and

best way to reach as many of our children as possible. We must educate our parents, beginning even with prenatal classes. We must teach them how to teach their children.

We must offer and support early childhood education classes. We know that children who are started early and have a good start are far less likely to be in our prison system or to fall behind in school. So we must support programs like Head Start.

We must provide comprehensive health education programs in our schools, from kindergarten to 12th grade, making violence in the curriculum an important part of that curriculum.

The final part of prevention is what I label hope. We must develop programs to train our young people and make jobs available for them. I am concerned that children today are not learning the skills they need to be employable and productive in today's work force.

I am worried that one-fourth of all young African-American males age 20 to 29 are incarcerated or on probation or on parole, whereas only 1 out of 5 are enrolled in higher education. These, I feel, are major problems which we must begin to address.

You asked me to speak about the implications for health care professionals. I join with my predecessor Surgeons General in urging our colleagues to recognize violence as a public health threat and as a potential immediate threat to all of our patients.

Let me add, when I talk about health professionals, I am talking about all of us. We all must become involved if we want to make a difference.

In closing, I want to highlight what we can do together. I feel we must care. We must care enough to change our concern about the problem into a commitment. We must have the courage to do what we know we need to do to save the most valuable resource we will ever have, our children.

We must change from concern to commitment by using all the tools of commitment. We must give of our time. We must give of our talents. And we must give of our treasures to begin to fight this major public health problem that is in our community.

We are aware of the problem. We must make our entire society aware of this problem. We must become advocates for the problems that we see as violence, and we must develop action plans that use all of our communities, using all of the resources that are out there and are available to us.

We must each reach out and be responsible for what is going on. We must use the resources of this government, the resources of our schools, the resources of our churches, and we must all join in this battle to deal with this major problem of violence.

And lastly, Mr. Chairman, I feel we must educate and empower our entire society to join in this battle to fight this major problem that is wiping out the most valuable resource we will ever have, our bright, young people. And I, as your Surgeon General, will be more than willing to lead this fight to try to turn this major problem around in our society.

Thank you for inviting me to be a part of this conference.

[The prepared statement of Dr. Elders follows:]

WRITTEN STATEMENT OF
M. JOYCELYN ELDERS, M.D.
SURGEON GENERAL
U.S. PUBLIC HEALTH SERVICE

Before the U.S. House of Representatives Committee
on Government Operations
Subcommittee on Human Resources and Intergovernmental Relations

Room 2247 Rayburn House Office Building

Monday, November 1, 1993
10:30AM

Good morning!

Chairman Towns, Mr. Schiff, and members of the Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Operations,

You have asked me here today to talk about "Violence as a Public Health Issue", and particularly to discuss the public health consequences of violence, efforts at prevention and the implications for health care professionals and institutions.

Before I get into particulars, let me tell you what I mean when I say that violence is a public health problem. First, violence is a public health problem because it kills and injures so many people, especially our young people and our children. Violence in America is an epidemic. It is one of the leading causes of death and injury for our young people. Gunshot wounds, including homicides, suicides, and unintentional shootings, are the leading cause of death for both African American and white teenage males, and they kill more teenage boys than all natural diseases combined. And for young African-American men and women 15 to 24, homicide is the number one cause of death.

From a public health perspective, the number of deaths caused by violence, which kills over 50,000 persons yearly, is greater than the number caused by AIDS -- which kills over 30,000 per year -- and greater than the number of deaths caused by drunk driving -- which kills nearly 18,000 persons per year.

In 1991, for the first time in our nation's history, the number of homicides alone exceeded 25,000. And the homicide rate for young males ages 15-34 in the U.S. is the highest of any industrialized country, roughly 20 times higher than rates in most other nations.

Second, violence must be considered a public health problem because the criminal justice approach alone does not work; it treats the problem after it occurs! Our prisons are overcrowded, our courts are backlogged, our police are overworked, and, still, our streets are not safe. We must couple prevention with our criminal justice system of treatment.

Finally, violence is a public health problem because it is a problem to be solved and must not be considered a fact of life. Violence is preventable. It is a learned behavior. As your Surgeon General, I am about preventing problems before they happen.

However, violence is a complex problem which has no simple solution. It is associated with and exacerbated by other social ills. As our First Lady has noted, violence is often spawned by

dependence, drugs, irresponsibility and hopelessness. To protect our children from becoming victims or perpetrators of violence, we must make changes. We must provide support to parents. We must help communities provide structure. We must provide hope to young people as they make their way from adolescence to adulthood. We must address the underlying causes of violence. To do anything else is to watch our children die.

EXTENT OF THE PROBLEM

The problem of violence in this country has increased markedly in recent years. There have been extraordinary increases in the rates of both homicide and suicide among our young people. Since the 1950's suicide rates among our youth have almost quadrupled, and homicide rates among young men are 20 times as high as most other industrialized countries.

As these rates have increased, the average age of both the perpetrators and the victims has fallen, so that increasingly we have a problem of children killing children.

- o Today, in America, 14 children under the age of 19 will die in suicides, homicides or accidental shootings. Many more than that will be injured.

Almost all of these increases in both youth suicide and youth homicide are attributable to increases in firearm suicide and firearm homicide. Firearms have accounted for virtually all the dramatic increase in homicides in African American males ages 15-24 from 1985.

- o Fifty-seven percent of all African American teenage males who died in 1990 were killed with guns. This is up from 48% in 1988.

So what we have is a country where children are killing children.

This problem of violence has spilled over into the schools, and in increasing numbers and proportions, kids are carrying guns to school.

- o In 1989, an estimated 430,000 students took a weapon to school to protect themselves from attack or harm at least once during a six-month period.

Violence is costing this country the most valuable resource we will ever have, our children. Our children are dying because they are being taught to use violence to solve problems. Violent behavior is being modeled in our homes, schools, neighborhoods and in the media. Children are learning daily that violence is a socially acceptable and even desirable response to others' behavior.

And, I add, much of this violence is family violence:

- o In 1990, there were over 500,000 reported and confirmed cases of child physical and sexual abuse. Evidence suggests that this may be only one-third the actual number of cases, and that much of it is drug and alcohol related..
- o Over 5,000 women dies as a result of homicide each year; 60 percent were murdered by someone they knew -- and half of those were murdered by their spouse or someone with whom they had been intimate.
- o And around 30% of the adult population experiences some form of spousal violence. Nearly half of husbands who batter their wives do so with brutal regularity, 3 or more times a year. And anywhere from 20 to 30% of emergency room visits by women are the result of domestic violence.

To me, as your Surgeon General, this is totally unacceptable. If we are to have true security in health care reform, we must restore security in our homes, our schools, our streets and our nation. I believe it is time for us to roll up our sleeves and rid this country of this hideous, highly infectious, yet preventable problem -- violence.

PUBLIC HEALTH CONSEQUENCES

The costs to this country are too great to ignore:

- o The cost of firearm injuries alone to our health care system is nearly \$3 billion a year.
- o The vast majority -- 85%-- of the hospital costs for treatment of firearm injuries is unreimbursed care. Violence is driving up the costs of health care. We, as taxpayers, are paying the price for violence in our society.
- o In the District of Columbia alone, the costs of criminal violence to hospitals totalled \$20.4 million in 1989.
- o And the total medical cost of all violence in the U.S. was \$13.5 billion in 1992 -- \$3 billion due to suicides and suicide attempts; \$10.5 billion due to interpersonal violence, including murder, rape, assault, robbery, drunk driving and arson.

In 1988, one out of six pediatricians nationwide treated a young gunshot victim.

And the toll is not just financial:

- o We can clearly document the immediate adverse psychological and physical consequences of violence, including family violence and rape. The long-term effects of such violence are seen in trauma-related disorders (including Post-Traumatic Stress Disorder, especially for rape victims), personality disorders, addictive disorders, and even physical disorders.
- o And we know that many violent individuals have experienced child abuse and become, in turn, abusive parents.

Causes of Violence

What causes violence and what can we do to prevent it? Many factors contribute to this epidemic in our society, but at its root is poverty. Related to poverty are changing family structures, the plight of our inner-cities, and the difficulties in our schools. Other key factors are the availability of alcohol and other drugs, firearms and weapons to younger and younger children.

Poverty and Its Context

Today, one of every five children lives in a household with income below the federal poverty line.

Most of these children will not become violent because their parents and their communities will provide structure and hope.

But poverty is not just the lack of money. It defines the context in which people live. And when poverty erodes the family and breaks down the community, it can confine the poor to fear and isolation -- and violence.

Lack of parental supervision is one of the strongest predictors of the development of conduct problems and delinquency.

Neighborhood instability coupled with poverty increases the likelihood of violence.

Alcohol and Other Drugs

The President's Interim Drug Control Strategy emphasizes the government's responsibility to protect its citizens from criminal harm. Drug use is behind much of America's problem with crime and violence. We have not focused enough on the link between violent crime and illegal drugs.

40% of all homicides are related to drugs.

In Washington, D.C., 80% of the homicide victims had evidence of cocaine in their bodies.

While illicit drug use for adolescents has declined markedly, evidence suggests that younger students' and college students' drug use is on the rise. With use up among the younger populations, we must take the drug threat more seriously.

And we have not paid enough attention to the impact of alcohol on all types of violence, and we must take this threat much more seriously as well.

In 65% of all homicides, the perpetrator and/or the victim had been drinking.

Alcohol is a factor in at least 55% of all fights in the home.

The abuse of alcohol or other drugs by parents has been associated with violent behavior by their children, and may put children at greater risk for abuse.

Weapon Availability

An estimated 1.2 million elementary aged, latch-key children have access to guns in their homes.

86% of the weapons confiscated in the Florida schools between 1986 and 1988 came from the students' homes.

In a 1987 survey, 48% of 10th grade boys and 34% of 8th grade boys said they could get a handgun if they wanted one.

An estimated 430,000 students took something to school to protect themselves from attack or harm at least once during a six-month period in 1989.

Having a gun in the home constitutes a very real and very serious threat. A recent study reported in the New England Journal of Medicine that if you have a gun at home:

- o You are 8 times more likely to be killed by, or to kill, a family member or intimate acquaintance.
- o You are 3 times more likely to be killed or to kill someone in your home.
- o You or a family member are 5 times more likely to commit suicide.

Firearms alone account for most of the recent increase in homicide rates among young men.

When youth who are already predisposed to violence have easy access to guns, they may be more likely to become violent.

Minorities and Violence

With its roots in poverty, violence has a disproportionately greater impact on racial and ethnic minorities. One of two African American children is poor. One out of three Hispanic children is poor. Up to 90% of all Native American children live in poverty. However, the violence exhibited in our society is not because of any racial or ethnic risk factor, but reflects an association between violence and poverty.

Although African Americans constitute 12 percent of population, 50 percent of murder victims are African American (50% of African American children live in poverty). And, let me remind you -- this is not interracial violence. In 1990, in 93% of the cases, African American offenders murdered other African Americans. Let me add that the vast majority of violence committed in this country is between people who know each other. White people kill white people. Black people kill black people. And Hispanics kill Hispanics.

Media Violence

The media depiction of violence weaves its way throughout these factors. By portraying violence as the normal means of conflict resolution, the media gives youth the message that violence is socially acceptable, "cool," and the best way to resolve problems.

We know after over 10 years of research, that a correlation exists between violence on television and aggressive behavior by children. I fervently hope that the media will become part of the solution by airing "prosocial" programming, by helping with public service announcements, by showing the true consequences of violence, by giving us all hope that we can turn this around. After all, they can reach more people in thirty seconds than I can reach in thirty years!

I made a strong plea last month for this in testimony on media violence before the House Subcommittee on Telecommunications and Finance, and I look forward to the media's response.

Let me add, that perhaps even more important than the violence children view on TV, is the violence that they see in their homes, in their communities, and on the streets. The violence that they see on the news is very real to them, and I believe that this "real" violence is even more frightening and disruptive to them. Our children witness fighting among their parents, and all too many even see one parent severely beat or even murder another parent.

This can leave scars that last a lifetime. I know of a woman who was shot and rendered quadriplegic by her husband has a young

son, now 11, who means all the world to her. For months he had nightmares that his father was chasing him with a butcher knife, and he went from an outstanding scholar to a problem child in school. After much therapy his school performance got better, he seemed outwardly happier -- but he was unable to acknowledge that his mother--who lived only to love him--was really his mother. It was too much for him to live with -- the fact that his mother was totally paralysed because his father shot her in the head with his .357 magnum. The impact of violence on our children leaves scars forever.

Let me now turn to what we, in public health, can do to help solve this enormous threat. We can't call out the military, we can't enforce gun control laws, we can't go on foot patrols in our neighborhoods. What we can do is help prevent violence before it starts.

EFFORTS AT PREVENTION

As President Clinton has said, one of the things our health care reform package and the anti-crime and anti-drug initiatives have in common is a focus on prevention. Under these, we will save money and enhance the quality of life.

Successful prevention means there will be something to say yes to for our young people. It means that the 50,000+ victims of violence would be alive and contributing to society. Prevention means that we would save at least \$13 billion each year in caring for the injured and the resulting disabled. Prevention means that we will protect our children and save our future.

In the case of violence, from a public health perspective, prevention means two things: reducing our children's risk of violence in the future, and preventing its immediate threat to our adolescents and young people. Let me add that what we do must deal with not only the individual child, but also the family, the social environment, and the community in a coordinated fashion. And what we do must be long-term -- since violent behavior is persistent, throughout adolescence and young adulthood.

That is why I personally have shepherded two pieces of the Health Care Reform package myself: comprehensive school health education and school-linked clinics for our students in junior and senior high.

Even though I want to focus today on the role of public health in preventing violence, I want you to know that we in the Department of Health and Human Services are working at all levels with other Cabinet agencies -- particularly the Departments of Justice, Education, HUD, and Labor, and the Office of National Drug Control Policy -- to develop a comprehensive plan to attack this

problem of violence, based on what works. Collectively, we are looking at six aspects of violence -- family violence, youth violence, sexual assault, media violence, and firearms.

Primary Prevention

Let me now return to what I know best -- the role of public health in all this. I want to address our efforts to prevent violence before it occurs -- or, in public health terms, primary prevention. In violence prevention, this means offering prenatal parenting classes and guidance, particularly to teen mothers and other parents at risk. It means starting early. That's why we must fully fund early childhood education programs like Head Start, and I ask for your promise to do so. Children who successfully complete Head Start are less likely to be incarcerated, to be on welfare -- and more likely to have high school diplomas than their non-Head Start counterparts.

You or I would do everything to help our children when they are in trouble, to give them a second (or third or fourth or fifth) chance. But poor children never get that second chance. Early childhood education programs like Head Start help them stay out of trouble so they don't need it.

Then our children go to school. I am convinced that school offers us the best and easiest way to reach as many children as possible, so my pieces of health care reform focus on what we can do in school.

Since I came last spring, I have been working with the Department of Education to put together a piece for Health Care Reform that would provide some funds for comprehensive health education in schools of highest need at first, and hopefully later, in all schools. Research has shown that comprehensive school health education is effective in influencing behaviors of our youth, and establishing a pattern of healthy behavior in the future.

I urge you to support this program. We can do more to turn this country around and to help our young people through comprehensive school health education than almost anything else.

This comprehensive school health education means, in part, a focus on "safety and the prevention of injuries" every day, in every grade, in age-appropriate ways. The most effective interventions begin with young children to shape attitudes, knowledge and behaviors while they are still open to positive influences.

This means teaching children how to resolve conflicts peacefully, especially those children at highest risk. We must work with our young minority males in the inner cities.

This also means supporting families through providing parenting classes, indeed, but also providing parents means to be part of their communities. We know that individuals and families connected to their communities are less likely to be abusive.

We must develop programs to train young people and make jobs available for them. It means making adolescents a part of our society and providing them a clear, positive role to perform. I am concerned that children today are not learning the skills they need to be employable and productive in today's work force. I am worried that 1/4 of all young African American males ages 20-29 are incarcerated, on probation or on parole, while only 1/5 are enrolled in higher education.

We are not naturally violent people. Violence is a learned behavior. It is learned from hopelessness, from a lack of hopeful and peaceful role models. And we can prevent it.

This type of violence prevention education must be available for families to address the need to break the so-called "intergenerational cycle" of violence, where children see abuse and violence and may be victims themselves, who then grow up to become violent themselves. We know that men who witness parental violence as children are much more likely to physically abuse their partners than men who have not, and the cycle repeats. We must break that cycle.

Today, I add my voice to those calling for the passage of the Safe Schools Act, an act that would provide schools the means to choose their own "weapons" against drugs and violence. Obviously, to me, that means a violence prevention curriculum that is an integral part of a comprehensive health curriculum.

Violence prevention, like math, cannot be taught at a special assembly. It must be taught every day, along with lessons in nutrition, exercise, substance abuse prevention -- all other healthful, preventive behaviors.

All of these are interrelated. In particular, early use of alcohol and other drugs is part of a cluster of behaviors, including early sexual activity, that lead to crime and violence. (According to Dr. Delbert Elliott, late onset of alcohol and other drug use is not related to crime and violence, whereas early use is. The pattern seems to be age 12 -- minor delinquencies; age 14 -- alcohol; age 16 -- marijuana; age 17 -- poly-drug use and sex; age 18 -- homicides.)

Reducing the Immediate Threat of Violence

Violence prevention also means reducing its immediate threat to our safety. It means revitalizing our neighborhoods and making them safe and cohesive places that collectively share the burden

of raising children by providing social structure and positive, peaceful role-models. We know that serious violence by older teens clusters in neighborhoods without this kind of structure and the means to provide adult roles to young adults/older adolescents.

Violence prevention means understanding the reason for gangs in our cities -- what needs do they fill, what security do they offer young people who do not find it at home or in school? And what kind of guidance are these youth seeking and what will they accept from their elders?

Reducing the immediate threat means removing the tools of violence -- guns -- from our schools, and providing opportunities for our children to make the transition into adulthood -- through community support and role models, through education and training, through knowledge that they can find jobs and hope for the future.

What the Public Health Service Is Doing

CDC is currently funding pilot programs on violence-related and unintentional injury prevention and control. These programs define and track injuries in their jurisdictions, develop interventions based on community needs and priorities, and evaluate the effectiveness of these interventions. Efforts pertaining to youth violence include:

- conflict resolution curriculums
- peer mediation programs
- surveillance of gunshot wounds treated in hospital emergency rooms
- safe routes/safe havens for school students
- positive parenting programs
- mentor programs

Twelve new projects will be evaluating a variety of school-based violence prevention strategies such as social skills building and conflict resolution training as well as victim education and counseling and adult mentoring.

These evaluations will teach us what works in teaching violence prevention -- and they can serve as the basis of the violence prevention component of comprehensive school health education. Currently, CDC is helping 5 states to implement comprehensive school health education.

Other PHS agencies also make important contributions to the Department's violence prevention goals. Programs of the Substance Abuse and Mental Health Services Administration (SAMHSA) work to prevent and treat two significant co-factors of violence, substance abuse and mental illness. The Office of Minority Health (OMH) funds grants for coalition building and other community-based activities, including violence prevention, targeted at minority males. The Maternal and Child Health Bureau of the Health Resources and Services Administration supports demonstrations to evaluate methods of reducing violence among children and youth, child abuse, and dating violence. The National Institutes of Health, principally the NIMH, sponsors biomedical and behavioral research on anti-social, aggressive and violence-related behaviors and their consequences.

The Administration for Children and Families (ACF) administers programs that focus on violence and substance abuse prevention for several at-risk adolescent populations such as gangs, runaway and homeless youth, and those who have been abused or neglected by substance abusing parents.

IMPLICATIONS FOR HEALTH CARE PROFESSIONALS

You have asked me to address the implications of violence for health care professionals. I join with my predecessor Surgeon Generals in urging our colleagues to recognize violence as a public health threat -- and a potential immediate threat to many of their patients. Let me add, when I talk about "health care professionals", I am talking in the broadest sense to include not physicians, but also school nurses, social workers, psychologists, mental health workers and even teachers.

On a day-to-day basis, health care professionals can:

- o become familiar with the AMA effort to have health care professionals identify and report domestic violence, and become trained to do the same. A key part of this training is learning to refer patients to appropriate social service agencies and shelters.
- o use the emergency room as a place to intervene by identifying persons who are victims or perpetrators of violence who may be at future risk, and referring them to needed services such as conflict resolution training, family counseling, problem solving training, substance abuse counseling and treatment, and other mental health and social services.
- o become trained in and offer prenatal counseling and guidance to expectant parents about early childhood development.
- o participate with their schools to develop health curricula

designed to promote healthful behaviors and to prevent violence and other destructive behaviors.

- o recognize and determine the immediate risk factors facing their patients -- with questions about gun storage at home, safety at school, aggressive behavior patterns at home or in school, and substance abuse.
- o become a credible source of information to their patients about preventing these problems -- by encouraging their patients to safely store guns where they pose less of a risk.

CONCLUSION

Now let me end by adding to my voice the voices of the President, the Attorney General, and other members of the Administration as we mount a all-out effort to stamp out violence in our society. President Clinton, in recent weeks, has strongly condemned the prevalence of violence in American society and he is firmly committed to breaking the cycle of violence in our communities. And the President has taken an important first step by endorsing the Brady bill. He has discussed banning semi-automatic assault weapons that serve no other purpose but to kill, and he has stated that we must get guns out of the hands of our children.

I am also pleased by the efforts Congress is making on this issue. In the last few months alone, there have been numerous hearings on this issue. I urge you to continue the dialogue. Your voices will be heard.

But I must add a voice of caution here. As I said at the beginning of my remarks, if we do not address the root causes of violence, we will be doing nothing. And, to address the root causes, we must nip violence in the bud -- prevent it before it starts. Without this public health approach, our efforts will be in vain.

In closing, I want to stress some of the points I have just made about the public health approach to violence prevention:

First, public health tells us that we need to focus on the PREVENTION of violence. Violence is not a fact of life. It is an epidemic but we can prevent it. To do this we need to focus our efforts on children and teach them carefully at school and at home, we need to provide them with educational and job opportunities, mentors, and opportunities to grow up without access to alcohol and other drugs. We can revitalize our neighborhoods. Within a few months, we will announce the details of "empowerment zones" and "enterprise communities" in which designated communities will receive cash assistance, federal tax incentives and coordinated economic and human development

services. We need less concentration on fixing the results of violence, more on preventing it.

Second, we have to keep guns out of the hands of children. We know that the problem is one of kids killing kids, and no one is going to argue with the need to keep them away from guns. There is no one simple solution to the problem of firearm injuries, but this is where we must start.

Third, violence is a complex problem and it will not yield to a simple solution. Violence prevention will require all of us working together, doctors and judges, teachers and police officers, scientists and community organizers. Violence is not just a minority problem or a problem for poor inner city residents--the solution will require black and white, rich and poor, city and country all working together.

Fourth, I want to tell you that there is hope and there is a solution to this problem. We must not retreat behind locked doors. We must become even more involved with our children and our communities. We must empower ourselves to make changes and then go out and make them. To do anything else is to sit back and watch our children die. As Surgeon General, I know that this is a preventable problem and I am committed to help lead us to the solution. Thank you so much for your attention and your support. I will count on it.

Mr. TOWNS. Let me thank you for that very powerful testimony. I think some of the things you are saying are things that really need to be done and need to be done right away. I appreciate the fact that you have devoted a great deal of time to this matter in your short tenure as the Surgeon General.

You indicated in terms of the media, and the role that they play. I know when we talk about censorship and all of that, that many people get nervous. How do you plan to deal with our networks? Because there is a consistent kind of feeling now that violence that we see on television plays a role in what is acted out in life. And someone has gone far enough to say that they feel that some of the youngsters are so confused, that they feel that maybe if they shoot somebody they might star on another episode the next week. They see you playing a role on television and you get shot and killed 1 week and the next week you come back a bigger star.

So some people are saying our young folks can't sort out the difference.

How do you plan to deal with the networks? Realizing that censorship is always something that people get nervous about.

Dr. ELDERS. Congressman, I certainly agree with what you are saying. I think that certainly—I know that this committee has been concerned and trying to look at ways of dealing with media violence. I think as your Surgeon General I plan to sit down with the media and try and see what they are going to do. And I will be working—I know the Attorney General has been very concerned about our asking the media to police itself and to respond. We know that to date they really have not been very responsive. But I think that we have got to somehow convince them of what they are doing in destroying our bright young people.

We know that it takes more than just the media. They see it in the streets, they see it in the home, but we know they see over and over on our television, 10 to 15 times an hour, they see violence on our prime time TV media. Sometimes 10 to 20 times an hour on our Saturday morning comics, which is just for children.

So we have got to ask them to be able to create prosocial programs. We can't continue the way we are. They have a role to play, and we must ask them to get involved in playing that very important, vital role.

They are the most powerful tool we have got against violence, and we have got to ask them to try to be responsive.

Mr. TOWNS. Thank you very much. I agree with you, and I appreciate your interest in the leadership in that as well.

Also, how do you plan to work with the State and local health departments to be able to deal with this question of violence as a public health issue?

Dr. ELDERS. Congressman, as you know, there are several things going on now in the Public Health Service. First of all, the President has asked for kind of a meeting of everyone, a task force put together across the governments on violence, and that has been formed, they have been working, and I am a part of that task force.

But second, CDC, the NIH, as well as HRSA, have programs going on in the area of violence at the present time. They are funded I think in approximately 20 States to try and help deal with these issues, working with our schools, working with our churches.

And as you know, I am honorary chairman of the United Methodist Church Shalom Zones, where the church is really getting involved in one community at a time, in getting all the churches, regardless of their denomination, involved, and dealing with the whole issue of violence, getting the hospitals involved, our judges, you know, involved. So we plan to really incorporate everyone into this, because we need everyone. We all have to be responsible.

We also have parenting curriculums to try to educate parents. We have developed violence curriculums which can be instituted in schools. Dr. Prothrow-Stith from Boston has developed a curriculum they have instituted in Little Rock schools, starting at a very early age. We had several schools where this has really been a major problem. And they did not have a fight in one of those schools for a whole year.

So we know that it works. We have got to educate our children on how to deal with confrontation in other than violent means.

Mr. TOWNS. Thank you very much.

Let me just raise one other question before I yield to my colleague, Congressman Payne. What has happened is that people see this as an urban problem. But as I look around, I see in rural areas that there is also a problem of violence. For some reason or other, this problem has not been highlighted.

How can we in some way or another point out that this problem is not only an urban problem, that it is a rural problem as well? Those areas may even have more difficulty if some way or another it is not addressed and addressed as soon as possible.

Dr. ELDERS. Congressman, you are absolutely correct. You know, I am from a very rural State, and we have one of the highest violences per capita of many States. So it certainly is both a rural and an urban problem.

I feel that we have got to make our citizens aware of the problem and get them all involved. I think there are a lot of people out there that would like to help and want to be involved, but they don't know how.

So again, this is one of the things our media could do. They could certainly begin to develop appropriate PSAs, prosocial, and reach out.

I had one of my TV announcers tell me one time, he said, Dr. Elders, I can reach more people in 30 seconds than you will in 30 years. My first response was to be upset about that. But if we have a weapon that is that powerful, we need to find a way to use it to reach all of our people.

Mr. TOWNS. I agree with you. Thank you very much, Dr. Elders.

I now yield to my colleague, Mr. Payne of New Jersey.

Mr. PAYNE. Thank you very much.

Dr. Elders, it is a pleasure to have you here. Let me just say, you touched on it a little bit, but I think that we both will agree that services that are—the integration of services is going to be critical to solving this problem—the medical community, churches, parents, and all, that is important.

I wonder how you will specifically use your role as Surgeon General, and could you define how you will be able to work your philosophy into the school system and with these other important groups in our society?

Dr. ELDERS. Congressman, I am very pleased that you asked that question. I want you to know that since I have been here I have probably spent more time meeting with Education than I have spent meeting with Health and Human Services. But that is because we are really very concerned about getting a comprehensive health education program which includes a violence curriculum into our schools. We feel that it needs to be started very early, in kindergarten, and make it age appropriate, and progress through the 12th grade.

So I feel that is very critical. I think the schools are ready, every major organization, you know, that is related to schools and that is related to health, has endorsed that we need a comprehensive health education program in our schools from kindergarten from 12th grade.

So I think the schools, perhaps with a little nudging and a little help from us, that this is something that could happen very quickly.

The schools are there, the teachers are there, the students are there, and we might have to give them some resources to help them do it, but they are ready, and I think they would save far more than it could possibly cost, to say nothing about the loss of life.

When we look at what it costs to keep one young man in prison for 1 year, that would almost pay for our curriculum.

Mr. PAYNE. Thank you very much.

Also, from what I understand, the Health and Human Services has structured what you call a youth violence prevention initiative which is targeting youth and young adults. Could you just briefly describe to us what the strategy involves and whether this would also be a part of this school program?

Dr. ELDERS. A part of the youth violence initiative, which is headed up by Dr. Peter Edelman and cochaired by a person from the Attorney General, Janet Reno's office, and it involves the Department of Labor, the Department of Justice—all of the different—several different agencies, Health and Human Services, SAMHSA, mental health, whatever, across the entire public—not just public health agencies but across the full range of agencies, they have been meeting, they have really formed several different groups, broken it down to several different groups, and one of them is really specifically related to youth violence, but they also have groups related to adult violence, abuse in the homes, and other kinds of abuse, and then other than youth violence, they also deal specifically with schools and the Department of Education is very much a part of that.

They are going to meet with people, with communities, and again, we have some small programs funded, but we really need to make this a nationwide program, because we realize that this is a problem that is really impacting our entire country.

Mr. PAYNE. Thank you very much.

Thank you, Mr. Chairman.

Mr. TOWNS. Thank you, Congressman Payne.

Let me say that, Dr. Elders, I am very pleased with your statement and your intention to get involved to help coordinate these activities. We feel very strongly a lot of this will have to be done

at the local level, and that the local agencies will have to be totally involved in helping to turn this around. Your commitment and willingness to work to assist them in every way is very, very encouraging. So we appreciate your leadership.

We appreciate the things that you are doing, and this committee looks forward to working with you to try to highlight the importance of dealing with this issue as soon as possible and to say to people in areas that have not been hit the way we have been hit in some of our urban areas, it is coming, and they need to work with us to try to bring it under control now. And whatever you can do in terms of helping to keep all of us together, we certainly appreciate that as well. Thank you so much for your testimony.

Dr. ELDERS. Thank you very much.

Mr. TOWNS. This morning we are pleased to be able to hear from one of our senior members of the Congressional Black Caucus, and indeed the House of Representatives, a person highly respected by all, who heads the Congressional Black Caucus health brain trust. I am delighted to invite to this table Congressman Louis Stokes from Ohio.

Congressman Stokes, we welcome you. We know of your involvement and the fact that you have been on this battlefield for a long, long time. We appreciate your leadership and we are delighted this morning for you to come and testify before the subcommittee.

You may proceed in any way you wish. Your entire statement will be included in the record, every period, every question mark, every I, every T. Thank you so much for coming.

STATEMENT OF HON. LOUIS STOKES, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. STOKES. Thank you very much, Chairman Towns, and Mr. Donald Payne.

Let me just firstly say, Mr. Chairman, what an honor it is to appear here this morning, and to have the advantage of hearing the excellent testimony that this subcommittee has just received from the Surgeon General of the United States. I think we are indeed fortunate to have this very talented and brilliant woman now heading this particular office and leading the charge now on behalf of the public, along with other tremendous responsibilities she has, and it is an honor for me to follow her in this chair.

Mr. Chairman, I will submit my full statement for the record, and I will ask permission just to summarize my statement at this time.

Mr. TOWNS. Without objection, the entire statement will be included.

Mr. STOKES. Thank you.

Mr. Chairman and members of the subcommittee, Mr. Payne and others, I appreciate the opportunity to appear here to discuss a very pressing national issue, violence as a public health problem. As the chairman of the Congressional Black Caucus health brain trust, and as a member of the Appropriations Subcommittee on Labor, Health and Human Services and Education, I have a great interest in the subject matter today.

I also want to commend you for the leadership you have exhibited in addressing this issue, and now bringing this national health problem to the forefront.

Mr. Chairman, the significance of violence as a public health problem in this country has been one of the most discussed and analyzed issues with the least amount of national call to action. As evidenced by your hearing today, it is very clear that we indeed are moving the Nation's response to violence from the analysis stage to the action stage.

By almost any measure you choose, violence ranks high as a public health problem. It affects all Americans and permeates every segment of American life, affecting our families, schools, hospitals, businesses, courtrooms and churches. By almost any measure it is an epidemic that is destroying the lives of our young people and endangering this Nation's future.

In the United States, violent and abusive behavior continues to be major causes of death, injury and stress. To review the data briefly, according to the FBI uniform crime report, in 1991 alone, homicides increased by 7 percent to 25,000; rapes increased by 3 percent to 100,000; robberies increased by 8 percent to over 690,000; and assaults increased by 3 percent to over 1 million. Mr. Chairman, truly violence has reached health epidemic proportions throughout America.

In recent years, the increases in violent crime in this country have set world records. Let me take a moment to share with you a few startling statistics which clearly indicate the magnitude of our Nation's problem on a global level.

During 1990, no nation had a higher rate of rape than this country. The U.S. robbery rate was nearly 150 times higher than in Japan. Furthermore, no nation had a higher murder rate than ours. In fact, no other nation was even close.

By 1991, murders in this country were more than double the murder rate in Northern Ireland, which is being ravaged by a civil war. Homicide might truly be characterized as a uniquely American affliction.

Even more staggering than the usual statistics which record the incidence of violence in our country are the statistics which suggest that the incidence of violence may be divided along racial lines. In 1989, an African-American male had a lifetime probability of being a murder victim of 1 in 27, compared to a white male's probability of 1 in 205.

Today, homicide has become the 10th leading cause of death in the United States. Homicide is the second leading cause of death by injury among African Americans, ages 1 to 19, the leading cause of death for African-American males and females ages 15 to 34—not cancer, not cardiovascular disease, not stroke. Homicide is the leading cause of death for our young people.

Similarly for Hispanic and Native Americans, the risk of homicide is also grave. In the Southwest, the homicide rate for Hispanic males was determined to be 3 times that of non-Hispanic whites. But for Native Americans and Alaskan natives, the rates of homicide were twice that of the rate for all Americans.

While we are experiencing what happens or appears to be increased violence between population groups and in certain areas of

the country, the reality of violence is that it occurs throughout America and not exclusively in the inner-city communities.

Moreover, Mr. Chairman and members of the subcommittee, as I am sure you would agree, it is distressing to see that far too many Americans, including many of our congressional colleagues, are still addressing violence from a strictly punitive viewpoint. They are not considering the underlying factors precipitating violent behaviors.

For the poor, disadvantaged and ethnic and minority populations, the roots of violent and violent crime are inextricably tied to other systemic failures and dysfunctions in a broader socioeconomic context. Poverty, education, unemployment, and homelessness, just to name a few, are all underlying factors of violence that are contributory or causal to homicide and assaultive violence, domestic violence, child abuse, sexual assault, suicide, and firearm injury.

The findings of a report recently released by the Government Accounting Office, title "Reducing Youth Violence," concludes there is a lack of coordination between the Federal agencies. There are not enough funds directed specifically toward youth violence prevention activities. And they are relying almost entirely on a criminal justice approach that simply is not working. A strategic plan for a public health approach must be developed to target youth violence treatment and prevention.

With the incidence of violence rapidly escalating, the need to find a solution to this dilemma is more immediate than ever. We just cannot afford to continue to ignore the fact that violence is a national health epidemic. The cost of doing nothing is far too great, in health, quality of life and economic terms.

The recent report to the Congress titled "Cost of Injury in the United States" indicates that firearm injuries ranked third in the economic toll on society. In fact, just 5 years ago, in 1989, they cost society \$14.4 billion. If that figure alone is adjusted for no more than 5 years of inflation at a minimum of 3 percent per year, the amount is now a staggering \$16.7 billion.

As 3 of the 5 leading causes of premature death—injuries, homicide, and suicide—are related to violence, we must support and expand violence treatment and prevention initiatives. This would ensure that the local communities receive the guidance and resources they need to reverse these trends.

This grim reality of violence demands an immediate national response. It is only through a collective and concentrated effort that a remedy to this grim reality would be attained.

Mr. Chairman, this Nation has effectively attacked a number of infectious disease epidemics. That basic blueprint and concentrated effort and resources must be applied to the violence epidemic. Violence has cast a sweeping shadow over America. It requires a national call to action to eradicate.

Some steps have been taken. They alone are not enough. The Department of Health and Human Services has established a framework for reducing the incidence of youth violence. It also is developing a youth violence initiative at the Centers for Disease Control and other agencies. These initiatives must be put on the fast track.

An excerpt taken from Dr. Deborah Prothrow-Stith's book entitled "Deadly Consequences" aptly describes the challenges we face today. In this passage, Dr. Prothrow-Stith quotes a woman whose two sons were shot in the same incident. One died and one did not. The woman is quoted in Dr. Prothrow-Stith's book as saying, "The children who are dying are real kids from real families. Somebody has to wake up and see that our children are dying. My child is dead. Your child could be next."

As Dr. Prothrow-Stith notes, it is time we paid attention to these frightening words. For it is clear that incarceration of offenders, the bandaging and burial of victims are ineffective antidotes. Our courts, jails and emergency rooms, school rooms and family assistance programs are all feeling the pressure of the swelling epidemic.

The very future of our Nation depends upon how we address these issues of violence. In its simplest and most complex terms, it really is a matter of life and death.

Mr. Chairman, Mr. Payne, other members of the subcommittee, we live in a Nation that put a man on the moon and developed the oral polio vaccine. Surely we can develop effective diagnosis, treatment, and preventive measures to solve the Nation's violence health epidemic.

Mr. Chairman, I would be pleased to answer any questions.

[The prepared statement of Mr. Stokes follows:]

STATEMENT OF
THE HONORABLE LOUIS STOKES
(D-OH)

VIOLENCE AS A PUBLIC HEALTH ISSUE

BEFORE THE
HOUSE SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL AFFAIRS

NOVEMBER 1, 1993

Good morning, Mr. Chairman and members of the Subcommittee. I appreciate the opportunity to appear here to discuss a very pressing national issue, "Violence as a Public Health Problem." As the Chairman of the Congressional Black Caucus Health Braintrust, and as a member of the Appropriations Subcommittee on Labor, Health and Human Services, and Education, I would also like to commend you for the leadership you have exhibited in addressing this issue, and for the cooperation and assistance you have afforded my advocacy to help bring this national health problem to the forefront.

Mr. Chairman, the significance of violence as a public health problem in this country has been one of the most discussed and analyzed issues with the least amount of a national call to action. As evidenced by your hearing today, it is very clear that we indeed are moving the nation's response to violence from the analysis stage to the action stage.

By almost any measure you choose, violence ranks high as a public health problem. It affects all Americans and permeates every segment of American life, affecting our families, schools, hospitals, businesses, prisons, courtrooms, and churches. By almost any measure, it is an epidemic that is destroying the lives of our young people and endangering our very future.

In the United States, violent and abusive behavior continues to be major causes of death, injury, and stress. To review the data briefly -- according to the FBI uniform crime report, in 1991 alone, homicides increased by 7 percent to 25 thousand; rapes increased by 3 percent to 100 thousand; robberies increased by 8 percent to over 690 thousand; and assaults increased by 3 percent to over 1 million. Mr. Chairman, truly, violence has reached health epidemic proportions in America.

In recent years, the increases in violent crime in this country have set world records. Let me take a moment to share with you some startling statistics which clearly indicate the magnitude of our nation's problem on a global level.

During 1990, no nation had a higher rate of rape than this country. During 1991, American women were 8 times more likely to be raped than European women. In 1990, the incidence of rape in America was 20 times higher than it was in Portugal; 26 times higher than in Japan; 15 times higher than in England; 8 times higher than in France; 23 times higher than in Italy; and 46 times higher than in Greece.

In terms of robbery, the difference in its occurrence here in this nation, as opposed to other countries is absolutely staggering. In 1990, the U.S. robbery rate was nearly 150 times

higher than in Japan; 47 times higher than in Ireland; and over 100 times higher than in Greece.

Furthermore, in 1990 no nation had a higher murder rate than ours. In fact, no other nation was even close. Americans are dying from unnecessary violent deaths in unprecedented numbers. The United States murder rate quadrupled Europe's. Consider for example, that in 1991 murders in this country were more than double the murder rate in northern Ireland, which is being ravaged by a civil war.

More specifically, in 1990, homicide in the United States was 11 times that of Japan, nearly 9 times that of England, over 4 times that of Italy, and 9 times that of Egypt and Greece. Given the substantial difference in the homicide rates in the United States as compared with other industrialized, and even pre-industrial countries, homicide might truly be characterized as a uniquely American affliction.

Even more staggering than the usual statistics which record the incidence of violence in our country are the statistics which suggest that the incidence of violence may be divided along racial lines. Both the Surgeon General's Report and the Secretary's Task Force Report on Black and Minority Health have clearly articulated the disproportionate impact which violence has had on the morbidity and mortality of racial and ethnic populations.

That delineation has not changed, even in 1989, an African American male had a lifetime probability of being a murder victim of 1 in 27, compared to a white males's probability of 1 in 205. Today, homicide has become the 10th leading cause of death in the United States. Homicide is also the second leading cause of death by injury among African Americans ages 1 to 19, and the leading cause of death for African American males and females ages 15-34. As compared with 17 other industrial nations, the homicide rate for African American males, between the ages of 15 and 24, ranges from 17 to 283 times greater.

Similarly, for Hispanic and Native Americans, the risk of homicide is also great. In the southwest, the homicide rate for Hispanic males was determined to be 3 times that of non-Hispanic whites. For Native Americans and Alaskan Natives the rates of homicide were twice that of the rate for all Americans.

While we are experiencing what appears to be increased violence in different population groups and in certain areas of the country, the reality of violence is that it occurs throughout America, and not exclusively in the inner city communities of Washington, D.C., Detroit, or Los Angeles.

Moreover, Mr. Chairman and members of the Subcommittee, as I am sure you would agree, it is distressing to see that far too

many Americans including many of our Congressional Colleagues are still addressing violence from a strictly punitive view point. They are not considering the underlying factors precipitating violent behavior.

For the poor, the disadvantaged, and many racial and ethnic minority populations, the roots of violence and violent crime are inextricably tied to other systemic failures and dysfunctions in a broader socio-economic context. Poverty, education, unemployment and homelessness, just to name a few, are all underlying factors of violence that are contributory or causal to homicide and assaultive violence, domestic violence, child abuse, sexual assault, suicide, and firearm injury.

The findings of a report recently released by the Government Accounting Office (GAO), titled "Reducing Youth Violence," concludes that there is a lack of coordination between the Federal agencies; there are not enough funds directed specifically toward youth violence prevention activities; and that relying almost entirely on a criminal justice approach simply is not working. A strategic plan for a public health approach must be developed to target youth violence treatment and prevention.

With the incidence of violence rapidly escalating, the need to find a solution to this dilemma is more immediate than ever. We just cannot afford to continue to ignore the fact that violence is a national health epidemic. The cost of doing nothing is far too great in health, quality of life, and economic terms. The recent report to the Congress, titled -- Cost of Injury in the United States, indicates that firearm injuries rank third in the economic toll on society. In fact, just 5 years ago, in 1989, they cost society \$14.4 billion. If that figure alone is adjusted for no more than 5 years of inflation, at a minimum of 3 percent per year, the amount is a staggering \$16.7 billion.

We must work together to encourage the Federal, State and local governments to view the issue of violence, not only as the number one leading cause of death of our children, but as a number one public health concern as well.

In fact, heart disease, cancer and stroke lead the list of causes of death. However, with regard to the leading causes of years lost prematurely, they are injuries, cancer, heart disease, homicide, and suicide. This reveals that 3 of the 5 leading causes of premature death -- injuries, homicide, and suicide -- are related to violence.

We must support and expand violence treatment and prevention initiatives, so as to ensure that local communities receive the guidance and resources they need to reverse these trends.

This grim reality of "violence" demands an immediate national response. It is only through a collective and concentrated effort that a remedy to this grim reality will be attained. Mr. Chairman, the nation has effectively attacked a number of infectious disease epidemics using the following approach. That basic blueprint, and concentrated effort and resources, must be applied to effectively address the violence epidemic.

The blueprint includes -- bringing the issue to the forefront; defining the problem; assigning lead responsibility to the appropriate agency; developing and utilizing appropriate education material and outreach approaches; designing, developing, and implementing intervention and prevention strategies; conducting assessment evaluations; providing the appropriate level of resources to help ensure the eradication of the problem; and measuring the quality of life outcomes to determine the program's effectiveness.

We must all continue to work together towards the goal of abolishing the unyielding tide of violence which touches all shores of our society.

Mr. Chairman and members of the Subcommittee, violence has cast a sweeping shadow over America that requires a national call to action to eradicate. Some steps have been taken, but they alone are not enough. The Department of Health and Human Services has established a framework for reducing the incidence of youth violence. We know that, it also is developing a public health approach to reduce youth violence with an initiative by the Centers for Disease Control and other agencies. These initiatives must be put on the fast track.

An excerpt taken from Deborah Prothrow-Stith's book, Deadly Consequences, aptly describes the challenges we still face. In this passage, Dr. Prothrow-Stith quotes a woman whose two sons were shot in the same incident. One died, and one did not. The woman is quoted as saying: "The children who are dying are real kids . . . They are real kids, from real families. Some were doing foolish things, and some were just caught in the wrong place at the wrong time. But all kids have a right to make mistakes. All kids have the right to live. Somebody has to wake up and see that our children are dying. My child is dead. Your child could be next."

As Dr. Prothrow-Stith notes, it is time we paid attention to these frightening words. All of us, here today, are familiar in some way with the violence that is plaguing our community. Many of us know someone who has been the victim, and in some instances a perpetrator of a violent attack. It is clear that incarceration of offenders, and the bandaging and burial of victims are ineffective antidotes. Our courts, jails, emergency rooms, school rooms and family assistance programs are all feeling the pressure of this

swelling epidemic. The very future of our nation depends on how we address the issue of violence. In its simplest, and most complex terms, it truly is a matter of life and death.

Mr. Chairman and members of the Subcommittee, our's is the country that put a man on the moon, and our's is the country that developed the oral polio vaccine. Surely, we can develop effective diagnosis, treatment, and prevention measures to solve the nation's violence health epidemic.

Mr. TOWNS. Let me thank you, Mr. Stokes, for your testimony. Very shocking statistics. Also, I would like to take this opportunity to thank you for the leadership that you have provided, not only for the Congressional Black Caucus, but for the Congress in health care. You have helped to highlight that this is an epidemic and that it is something that we must begin to deal with. Though, as it was pointed out earlier on the front page of the Washington Post, we find that children as young as 10 years of age are planning a funeral and young people will say to you that I know I will never reach the age of 21 so I am not even thinking about it.

Let me ask you, what hope can we offer these children that policymakers can end the cycle? I'm not afraid to ask you because I know you have been out here on the firing line for quite some time. What can we do now to begin to give them some hope?

Mr. STOKES. I think, Mr. Chairman, that we must begin to work with our local communities. We must begin to work with those who have formerly been gang leaders and members of gangs who now want very badly to reform the system. They want help. They are reaching, crying out.

During the Congressional Black Caucus weekend, we conducted a hearing on violence in the health brain trust. We have satellite feeds into Cleveland and into Memphis, TN. We see former gang members, former gang leaders who are now working with local police officers and local community organizations, local churches, trying to be a part of the system, trying to break themselves from a way of life that they knew was wrong, but which they couldn't break from without some type of societal help. We have to help them be able to do that.

Congress has to fund the kind of programs that will enable us to have these kind of initiatives at the local level. We must begin in our various agencies at the national level and we must give them the kind of legislation they need as we look at national health care reform. We must make violence an integral part of the health care reform practice.

In the legislation which I will be introducing in a few days, which all of you are cosponsors of, the Disadvantaged Minority Health Act, which is up for renewal, I hope that we in that legislation will be able to include some measures that help local communities be able to start fighting this problem, and let these young people know that we really care about them and their lives.

Mr. TOWNS. Thank you very much, Congressman Stokes. Let my just say to you that I know you are on the Appropriations Committee and you have to fight for it there as well. I want to let you know that we join you in that fight. I now yield to Congressman Payne.

Mr. STOKES. Thank you, Mr. Chairman.

Mr. PAYNE. Thank you very much. Mr. Stokes, as indicated, in the Post story today, it talked about the fact that in the last 5 years, 224 youngsters under the age of 18 have died right here in the District of Columbia. In New York City, the number of violent deaths by gunfire is at about 350 already this year. Washington, DC tends to have close to 500 deaths per year.

Just last week in my district, in Jersey City, I went to the site where, the night before, three young men pulled guns, shot at each

other and all three were killed by each other. It is just happening all around.

Reverend Jesse Jackson was in New Jersey on Saturday and talked about a 4-year-old girl was killed last week by some stray gunfire here in Washington and then he went on to talk about the whole cycle of violence because the girl's mother—had her at the age of 15. The grandmother was only 37, but had died from a drug overdose, that the father of the 4-year-old could not attend the funeral because he was in maximum security for killing a 4-year-old when he was younger.

And so this can't continue. This is genocide. It just is out of control—it is just out of proportion, and so I would just say that it is sad when on 60 Minutes yesterday I saw a program where Japanese tourists are being taught how to enjoy United States of America, but what to do about violence. That has to be a part of a tourist's education. You know, see the Statute of Liberty, see the Capitol, but also if someone comes, let your pocketbook go and how to say certain words.

So I think that this Nation has to become serious about dealing with the problem of violence. I think that perhaps it is more serious now, in fact, it is no longer contained to certain segments of our society, but as we saw with the drug problem, since we allowed the drug problem to continue rather than nipping it in the bud, and it has grown to affect the entire country. And now, violence affects the entire country, not only the inner cities where currently people look the other way because it won't happen to them.

So I just cannot congratulate you enough for your leadership in this whole question of violence as a health problem, and I just say that we will continue to follow your leadership in this very dreadful situation. Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. STOKES. Thank you, Mr. Payne.

Mr. TOWNS. Thank you very much. Let me thank you, too, Congressman Stokes, for coming and sharing with us, because you have been out there a long time, but I must admit that as bad as things are, I am encouraged in a lot of ways.

When I listened to the testimony this morning of Dr. Elders and now I listen in terms of you and the kind of things I know that you would like to see happen, I think that is encouraging. So what we have to do is just continue to fight and make certain that everybody is aware of this problem, and those statistics that you have described, I think a lot of folks are not aware of just how bad this situation is and once they see it and begin to recognize that this is a war and that we need to commit the necessary resources to put an end to the bloodshed and we need to end it right away because we are losing far too many lives.

So thank you very much for your testimony and taking the time to come before the committee this morning.

Mr. STOKES. Thank you, Mr. Chairman, Mr. Payne. Thank you very much.

Mr. TOWNS. I would like to call up the panelists from panel one, Dr. Mark Weist, and the student from the Baltimore city school system, Ralph Green, and from my own congressional district, I would like to call on Madeleine Daly. Please come forward, take a

seat at the witness table. I also understand that Dr. Beverly Jackson has a family emergency which will require her to leave, so what I would like to do is ask her to join the panel now, and take a seat at the witness table.

Dr. Jackson, I understand you have an emergency. So what I would like to do is ask you to go first to allow the committee the opportunity to raise questions with you and also permit you to carry on with your family emergency. Thank you so much for coming this morning, Dr. Jackson.

STATEMENT OF BEVERLY ROBERSON JACKSON, DIRECTOR OF PUBLIC POLICY/PUBLIC EDUCATION, ZERO TO THREE NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS

Ms. JACKSON. Thank you very much, Chairman Towns. Thank you for allowing me to testify and make my family emergency. To Chairman Towns, Congressman Payne, members of the Subcommittee on Human Resources and Intergovernmental Relations, National Center for the Clinical Infant Programs appreciates this opportunity to testify this morning. I also saw the Washington Post headline "Preparing To Die Young."

I, unfortunately, felt that it missed the boat and what we found in our findings is that it really actually has. You can ask child care providers and Head Start providers here in Washington about the 2, 3, and 4-year-olds that play drive-by shooting and funerals. "I won't attend your funeral" has now replaced, "you are not invited to my birthday party" as the words that hurt 4, 5, and 6-year-olds.

Our very young children have been extremely impacted by the violence in our society. Zero to Three, the National Center for Clinical Infant Programs is the only national organization that focuses solely on children and family at the very earliest years of life.

Everything we have learned about childhood and family development in the past several decades tells us that what we see in the behavior and emotional adaptation of elementary school children and adolescents can be traced in large part to experiences in the earliest years of life.

What these studies, although preliminary, have found is that many of our children are in serious trouble. They have been harmed by violence, whether or not they have been injured by bullets or knives.

Our board members have participated in a number of surveys and studies. Barry Zuckerman, chairman of pediatrics at Boston City Hospital wrote a commentary for the January 1993 issue of the Journal of the American Medical Association. He focused on the findings of a study of children admitted to or examined at Boston City Hospital. These were children under age 5, the average age being 2.7 years.

Had witnessed knife or gun attacks were 10 percent; 19 percent had witnessed physical abuse, kicking or punching. Half to one-third of these incidents were recent and frequent acts; 50 percent of those children had witnessed acts occurring in the community; 50 percent had witnessed these acts occurring in the home.

Dr. Joy Osofsky on our board, and at the Louisiana State Medical Center conducted a survey similar to one conducted in Washington, DC with elementary school-aged children. Over half of the

New Orleans fifth graders in her study had been victims of some type of violence; 6 percent had been victims of severe violence. Over 90 percent of the children in both studies had witnessed some type of violence. And 37 percent had witnessed severe violence, 40 percent had seen dead bodies. Over 70 percent of the children in both studies had witnessed weapons being used.

Both of these studies reveal a high reported incidence of post traumatic stress disorder. Of the older children in the study, 40 percent of the New Orleans children and 15 to 20 percent of the DC children said they worried about being safe, felt jumpy and scared. But that is almost the good side of it.

The other side is that when the trauma ceases to be trauma, there is an increased tolerance to violence, almost an immunization against violence. At Zero to Three, we focus on prevention and as one of our board members, Dr. Gloria Johnson Powell, at Harvard School of Public Health has said, it is not too late, but it is very late in the game when you focus on a disaffected 15-year-old. You need to look at children when they are initially affected by violence.

Our Zero to Three study group found that violence in its various forms cannot be disentangled. One type of violence cannot be reduced without addressing others. Family violence as exhibited in child and spouse abuse is not a different form of violence from that experienced in society. Family violence and societal violence are all on a similar continuum. They have an impact on each other and frequently affect the same individuals.

The attitudes that tolerate and ignore violence in society as a whole also tolerate the violence acted out in individual communities and homes throughout the country. When a child is victimized or witnesses violence, it has a deep immediate and perhaps long-term impact. We have learned from the recently released National Institute of Justice report by Cathy Spatz Wisdom, entitled, "The Cycle of Violence," that early exposure to domestic violence increases the likelihood of arrest as a juvenile by 53 percent, as an adult by 38 percent, and an arrest for a violent crime by 38 percent.

At Zero to Three, we have looked at a number of issues that we believe need to be addressed. One is a family centered approach to addressing trauma and prevention. Many of the 15 to 18-year-olds that are in youth violence projects also have children. Those younger children may also have been traumatized. They all need to be worked with together, and the services need to not be fragmented toward one age group or another, but a full family centered group of services.

We look toward a realignment of values. Violence and violent acts are viewed as entertainment by this society so everyone in this society has a part to play in our tolerance for violence. When our awareness as a society was raised about drunk driving, our society began to stop tolerating the funny drunk driver or the funny drunks on TV programs.

When most people began to see smoking as antisocial behavior, then the number of adult smokers began to decline. There needs to be a public health approach, a public health communications, as well as public health services approach to prevention of violence.

Dr. Jim Garbarino uses the car seat example; 20 years ago we didn't know about car seats. But now, car seats are provided when children leave hospitals in many cases. Many times you will see car advertisements talking about built-in car seats. They looked at the whole structure of automobiles and changed it and added a range of things to make cars more safe for children.

There has to be a full awareness campaign about violence, and as Congressman Towns said, violence is not a big city problem. I am raising children here in Washington, but I can't propose to take my children to Newton, KS and find it safer. That is where I am from, that is where I am journeying to, because in that town of 16,000, 90 percent white, there are drive-by shootings. So it is not a racial issue specifically. It is not confined to inner-city areas. This is a problem throughout the country.

Gang violence occurs in towns with upwards of 20,000 residents affecting people in States traditionally not associated with violence; States as Kansas, Arkansas, Mississippi, and Louisiana. Not the violence we are talking about today.

Our society has been able to tolerate growing trends in violence with little outcry. In 1991, 1,383 young children, half of them under age 1, died from abuse and other intentional injuries. Guns killed 222 children under age 10 in 1990. During the same year, only 68 people of all ages were killed by handguns in Canada which has similar economic and population patterns.

We call upon legislators on all levels of government to do a number of things. First, to address the crippling problem related to indiscriminate gun sales and purchases. Ensure that parents understand the responsibility in gun ownership and keep handguns and other weapons out of the hands of children. Refine the existing fragmented services that are provided for families in the area of prevention, and also I understand in the House there is going to be introduced a child and family services and law enforcement partnership bill to match the one in the Senate.

We think that that is a very, very encouraging outcome. National policies also need to address the amount of violence children can watch on TV and in the movies. According to TV guide, a violent incident occurs every 6 minutes on American television.

Thank you very much for your time.

[The prepared statement of Ms. Jackson follows:]

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Prepared by: Beverly Roberson Jackson, Ed.D.

Chairman Towns, members of the Subcommittee on Human Resources and Intergovernmental Relations of the U.S. House of Representatives Committee on Government Relations, **ZERO TO THREE/** National Center for Clinical Infant Programs (NCCIP) appreciates this opportunity to provide testimony on "Violence as a Public Health Issue."

My name is Beverly Roberson Jackson and I serve as Director of Public Policy at **ZERO TO THREE** and staff to our Study Group on Violence, composed of members of our Board of Directors from varied disciplines including medicine, sociology, psychology, social services and family counseling. I am also a parent trying to rear mentally healthy young children in the midst of the violence here in Washington, D.C.

Debra Jones, 31, who lives in an apartment where the bedroom window shade has bullet holes from "when they came by spraying" during a random shooting, said her two-year-old daughter knows gunfire when she hears it. "She says, 'Get down, get down Mommy.'"

--from "I'm Sacred to Come Outside': In a Violent Corner of D.C., Survival Training Starts Early," by DeNeen L. Brown and Patrice Gainse, Washington Post staff writers (September 28, 1993)

The December 7, 1991, edition of The Washington Post included a news story with the headline, "In D.C. Neighborhood, Two Killings in a Half Hour." Violence in the District and other communities has been persistent over the past few years and continues to have an impact on the lives of children. Yet this paragraph from the middle of the news article still startles:

A police officer angrily ordered a woman to remove a boy, no older than 4, who stood and watched as the dead man's bloody torso was examined in full view of the crowd. "That's what you have to do," replied the grandmother, who said she was trying to teach the boy a lesson. "Show them real life. Don't honeycoat it."

"Real life," for millions of children, young people, and families in this country is anything but honeycoated. As the only national organization concerned solely with children and families in the earliest years of life, **ZERO TO THREE/National Center for Clinical Infant Programs (NCCIP)** has been aware since its founding in 1977 that poverty, racism, and other community and social ills constrict children's life chances even before their birth. As an association of leaders in infant and toddler health, mental health and child development with representatives from the fields of mental health, pediatrics, nursing, occupational therapy, psychology, psychiatry, human development, social work, education, special education, business and philanthropy we decided to apply the strength of our respective disciplines to this inquiry. The increasing incidence of violence in communities across the country and the complexity of the problem prompted us to create a Study Group within **ZERO TO THREE** to focus on the specific impact of violence on the development of infants, toddlers, and their parents.

Everything we have learned about child and family development in the past several decades tells us that what we see in the behavior and emotional adaptation of elementary school children and adolescents can be traced in large part to experiences in the earliest months and years of life. What these studies, although preliminarily, have found is that many of our children are in serious trouble. They have been harmed by violence, whether or not they have been injured by bullets or knives.

Our Boardmembers participated in a number of surveys on the amount of violence witnessed by young children in the U.S. For example,

Barry Zuckerman, Chairman of Pediatrics at Boston City Hospital wrote a "Commentary" for the January 1993 issue of the Journal of the American Medical Association. His comments focused on critical findings from a study of children examined or admitted to Boston City Hospital. He found in this survey of children under age five, the average age of whom was 2.7 years, that many had witnessed or been exposed to violence in their young lives.

- 10% had witnessed a knife or gun attack
- 19% had witnessed physical abuse (kicking, punching)
- 1/2 - 1/3 of these were recent, frequent acts
- 50% of witnessed acts occurred in the community
- 50% of witnessed acts occurred in the home

Research is beginning to learn more about children's exposure to violence, so that this knowledge can be used as a basis for developing prevention and treatment programs. Most current research efforts examine the impact of violence on children of school-age or older, not on infants and toddlers. John Richters and Pedro Martinez of the National Institute of Mental Health sought to describe the extent to which young children living in a moderately violent inner-city neighborhood had been exposed, both directly (as victims) and indirectly (as witnesses) to various forms of violence, and the correlates of these exposure patterns on the children's social and emotional functioning. Joy Osofsky, Sarah Wewers, Della M. Hann, and Ana C. Fick at Louisiana State University Medical Center conducted a similar survey in New Orleans. There were 165 children, aged 6 to 10 years, in the Washington, D.C., sample and 53 fifth-grade children in the New Orleans sample. Overall, children's exposure to violence in the two communities was similar (Richters & Martinez, 1992; Osofsky, Wewers, Hann, & Fick, 1992).

- o Over half of the New Orleans fifth-graders had been victims of some type of violence; six percent had been victims of severe violence.
- o Over 90 percent of the children had witnessed some type of violence. Thirty-seven percent had witnessed severe violence. Almost 40 percent had seen dead bodies.
- o Over 70 percent of the children had witnessed weapons being used.

All of these studies revealed a high reported incidence of Post Traumatic Stress Disorder. Of the older children thirty to 40 percent of the New Orleans children and 15 to 20 percent of the Washington, D.C., said they worried about being safe. Children feel "jumpy" and "scared" in similar proportions. As could be expected, mothers were very concerned about their children and the kinds

of environments in which they had to live.

Neither national statistics on violence nor the findings of the Washington, D.C. and New Orleans surveys address specifically the impact of community violence on children from birth to three and their families. The effect of unexpected violence leaves its mark on individuals of any age, as many a Vietnam veteran will attest. In fact, "post traumatic stress syndrome" has become a term in the psychiatrists' lexicon and an important domain for research. But just as a baby learns to move his whole body before he can use an arm and then two fingers, so the impact of the very young child's exposure to random violence is more global than it is on an older child or adult. It is easy to think the infant is too small to understand violence. In fact, it is because he doesn't understand it specifically, that the experience is likely to take on sinister and magical dimensions. It cannot be slotted in its logical place. And where violence is combined with the actual loss of a parent or caregiver who is the center of the baby's whole world, the depression of a loved one or caregiver due to loss, the fear of going outdoors, the belief that parents cannot be trusted to protect him, the impact is all the more severe.

Elizabeth Simpson, a former social worker for a project of the Oakland California schools, described the effects of PTSD on young children at the first ZERO TO THREE event examining this issues in 1991.

o Anxiety, lack of impulse control, poor appetite, poor concentration, and flat affect are common. It is significant that the feeling states, both pleasant and unpleasant, of children exposed to persistent violence appear limited. There is a certain dullness about these children, a lack of creativity apparent in their restricted play. Being overly defended, some children deny any danger or fear, denying them access to a whole range of rich feelings. With other children, we see dramatic play which often seems to be a direct re-enactment of the frightening situations that they have experienced. It is full of collapsing buildings, car accidents, burning children, children thrown from windows, or children jumping from roofs.

o Children frequently experience sleep disturbances, including nightmares. In response to their anxiety, children sleep with adults or older siblings far beyond the age that we might normally expect. Sleeping together provides comfort to both adults and children... [A number of our Boardmembers who have pre-adolescent children have noted a marked increase in their children's requests to sleep near them at night rather than in their own rooms. This has been noted to happen especially after a violent incident has been reported. The incident need not have occurred in their own neighborhood, it could have occurred in a nearby urban or rural area.]

o Somatic complaints and stress-related syndromes are common. Headaches, stomach aches, back pain, and asthma attacks occur frequently in the morning before school. When they occur during school hours, children are often inconsolable until they are sent home. Children who have spent long periods at home recovering from illness or accidents have great difficulty returning to school; their mothers commonly stay with them in the classroom upon their return. Although difficulties would be expected among many children returning to school after a prolonged illness or family trauma, the regression that we observe [as a result of violence] seems extraordinarily persistent and prolonged.

o School phobia and school avoidance seem linked to children's fears about their parents' welfare.

School phobia and school avoidance can be symptoms of a number of disorders. We believe that, consciously or unconsciously, many children are afraid of what might happen to their mothers or younger siblings when they are away from home. Depending upon the child's defense mechanisms, this worry is either verbalized or acted out. Even when children do not avoid school altogether, their worries diminish their ability to concentrate. Coupled with other life circumstances, the high level of distraction and immersion in fantasy contribute to the academic failure of large numbers of children.

The ZERO TO THREE Study Group found that violence in its various forms cannot be disentangled; one kind of violence cannot be reduced without addressing others. Family Violence as exhibited in child and spouse abuse is not a different form of violence from the violence experienced throughout society. Family violence and societal violence are all on a similar continuum. They have an impact on each other and frequently affect the same individuals. The attitudes that tolerate and ignore violence in society as a whole also tolerate the violence acted out in individual communities and home throughout the country.

When a child is victimized or witnesses violence it has a deep immediate and perhaps long term impact. We have learned from the recent National Institute of Justice report by Cathy Spatz Widom, "The Cycle of Violence", that early exposure to domestic violence increases the likelihood of arrest as a juvenile by 53% as an adult by 38 and arrest for a violent crime by 38%.

Joy Osofsky, Professor of Pediatrics and Psychiatry at Louisiana State University Medical Center and Chair of ZERO TO THREE's Violence Study Group, summarizes some actions that can address the impact of violence on infants, toddlers, and their families, including:

- o Helping victims of violence immediately and over time, recognizing that the internalization of exposure to violence can have effects lasting over generations;
- o Supporting parents as they protect their children's physical and emotional well-being, and organize to strengthen each other's efforts;
- o Training front-line service providers and providing them with ongoing consultation and emotional support;
- o Training parents and child care providers to help very young children learn conflict resolution;
- o Addressing the impact of violence on television; and
- o Shaping public policy in all areas of prevention and intervention that are related to violence -- including community development as well as crime prevention and control.

Finally, ZERO TO THREE is working to identify other research, intervention, and policy initiatives that address the impact of violence on children and families. We believe that the first steps toward violence prevention begin at birth. The development of strong, healthy, emotional relationships during infancy is critical to the future development of a child. Our resource, *Heart Start: The Emotional Foundations of School Readiness* stresses that "...such basic human capacities as the ability to feel trusting, to experience intimacy with others and to negotiate with others, begin to develop

from a child's earliest moments." It is our strongest wish that all children will be welcomed into this society at birth by parents and society as a whole without prejudice and barriers to their future success.

In April of this year we published a "Call for Violence Prevention and Intervention On Behalf of Very Young Children" based on two years of study which included convening a consultation of experts, a Seminar calling together child advocates, researchers and clinicians to discuss the issue. As a result of this inquiry, **ZERO TO THREE** further recommends:

1. a family centered approach to addressing trauma/prevention;
2. a realignment of values; and
3. informed comprehensive public policy strategies for reducing violence.

Following is a synopsis of each of the above agenda items.

Family Centered Approach to Addressing Trauma/Prevention

We recognize that parents need help in coping with the violence around them; they need information about what to tell their children about violence; they need skills in non-violent problem/conflict resolution.

Children exposed to violence need healing for the trauma they have experienced. Very young children exposed to violence represent a special group because they are less able to talk about their violent experiences, more apt to experience overwhelming loss, and more likely to react globally to a fearful experience, even if they fail to "remember" it in adulthood. Children of all ages need skills in non-violent problem resolution and, above all, a hope for a future without violence.

Practitioners who work with children like child care workers, pediatric trauma nurses, school nurses and counselors have also been traumatized by the increasing numbers of children affected by violence and the violence around them. They need information about how to work through their trauma as well as how to engage children in discussing their own hurt and fear. They also need information about how and when to seek additional therapeutic services for themselves or the children and families they serve.

Our first step in this endeavor has been to prepare a document for parents and caregivers that examines violence and its impact on families and young children. It will be released in December. This document will include an easy to understand interpretation of recent research in addressing trauma and developing resilience and conflict resolution skills designed for parents and others who work directly with children and families.

Realignment of Values

There are many things that clinicians cannot do alone. There is a need in society for a realignment of values concerning violence. Violence and violent acts are viewed as entertainment. When our

awareness was raised about the consequences of drunk driving, our society ceased to tolerate or be entertained by the "funny" drunk driver weaving through traffic. When most people began to see smoking as antisocial behavior, the numbers of adult smokers began to decline. There needs to be a campaign against violence as strong as Mothers Against Drunk Driving (MADD), or the public health campaign against smoking to change attitudes and values about violence.

Violence is not a big city problem; drive-by shootings occur in towns with populations of only 16,000. Gang violence occurs in towns with upwards of 20,000 residents, affecting people in states not traditionally associated with violence -- states such as Kansas, Arkansas, Mississippi and Louisiana. Our society has been able to tolerate growing trends in violence with little outcry. For example --

- In 1991, 1,383 young children died (half of them under age one) from abuse and other intentional injuries in 1991.

- Guns killed 222 children under age 10 in 1990 in the United States. During the same year, only 68 people of all ages were killed by handguns in Canada.

As we re-evaluate our tolerance for violence we should call on ourselves and others to examine our responsibility for violence. Each person who commits a violent act is ultimately responsible for that act. The choice between violence and non-violence must be examined. What are the policies that support the choice of non-violence? Are there policies that provide incentives that support a choice of non-violence? What are the rewards in society for selecting non-violent options?

Prevailing attitudes and policies support investment in dis-incentives to violence. Dis-incentives like arrest, incarceration, etc. are expensive. There should be more investment in preventing violence. More money is invested on the federal, state and local levels in building and expanding prisons than building and expanding safe, clean and affordable housing. Can we as a nation balance our expenditures on dis-incentives with our investments in prevention?

In large and small communities around the country, families have begun small scale campaigns against violence. Parent and victim organizations need to come together, bringing with them their current concerns about gun laws, drug laws, etc. and confront societal attitudes about violence. Issues related to incentives for choosing a non-violent lifestyle and personal responsibility for actions need to be a part of the agenda, along with the task of changing attitudes and behavior.

We call upon our political leadership to bring these groups together with media leaders and launch a campaign to change our national attitudes toward violence and our tolerance of violent behavior.

Informed Comprehensive Public Policy Strategies for Reducing Violence

Finally, we call upon legislators on all levels of government to begin to develop a rational approach to addressing the impact of violence in our society.

National policy should do several things --

- First, it should address the crippling problem related to indiscriminate gun purchases -- ensure that

parents understand their responsibility in gun ownership and keep handguns and other weapons out of the hands of children.

●National policy should refine the existing fragmented services into a more goal directed set of violence prevention and follow-up services that will include very young children and family-centered mental health strategies. Some models include:

-Hawaii's Healthy Start Program that provides visits to all families of newborns, identifies and provides prevention services, emotional support, family crisis resolution strategies and mental health services to at-risk families. On the mainland, The National Committee for the Prevention of Child Abuse and Ronald McDonald Children's Charities are trying to replicate this in states around the country.

-In Boston, Mass., New Haven, Conn., New Orleans, La., and Washington, D.C., there are university-affiliated projects that provide resources and coordinate the work of child and family services and mental health professionals to intervene in cases where a violent crime involves a child either as victim or witness. These services are coordinated with law enforcement and special police training programs to provide community-based help and follow-up toward the reduction of the effects of long-term trauma (PTSD) on these children. Senator Christopher Dodd (D-Conn.) recently introduced legislation to broaden this type of program through a Child and Family Services and Law Enforcement Partnership.

●National policy should address the amount of violence children can watch on television and in the movies. (According to *TV Guide*, a violent incident occurs every six minutes on American television.)

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Mr. TOWNS. Thank you, Dr. Jackson. What we will do is sort of deviate from the normal pattern here and raise questions with you and then we will go back to the regular panel, Congressman Payne.

I have one question for you. You know, when you talk about the fact that young people are saying you are invited to my funeral and not my birthday party I think it really points out that this is a public health crisis, that we must begin to deal with to turn this matter around. We will have to put some resources to be able to do it.

Under health care reform, this is my question, what violence prevention services do we need to direct toward families with infants and toddlers? What do we need to do to be able to turn this situation around?

Ms. JACKSON. One of the things that we need to do is recommended by the black caucus of the American Public Health Association, and that is that we begin to look at the fact that children very, very early in life begin to internalize ways of solving problems, internalize the things that they see.

For example, a small child that sees violence, the same way that they learn a variety of things, they start with larger movements and then get down to the smaller movements. When they see violence, violence is very global to them and they interpret it very differently than, let's say, a teenager who first sees violence. So violence becomes a part of their life, an accepted part of their life, so that when my 3-year-old heard that someone had died at church, his first response was, who shot her?

Violence, killing people, becomes a natural point of view for many children. The national—the black caucus of the APHA suggested that conflict resolution, violence prevention strategies, as well as therapies to work—help children work out violence and the violence they have seen start in the preschool area, not wait until elementary school, but start in the very, very early ages for children.

Mr. TOWNS. Thank you very, very much. I yield to my colleague, Congressman Payne.

Mr. PAYNE. Yes, I think that the question that you raised about the trauma, the little children's games, but more importantly the fact that the tolerance level for violence is rising, and that is the scary part. I think that there are just—it seems to me that there is a need for people to—young people to seek attention and recognition from their peers and this becomes very serious because in Newark, NJ, we are seeing a new phenomenon, a tremendous problem with motor vehicles—with automobiles being used as a weapon, and sometimes there is even occasional riding on a sidewalk with a vehicle or a vehicle being driven in reverse.

These are very serious questions because it seems acceptance is being sought, and therefore, what do you feel about the whole societal situation where large segments of our society feel less than first class by virtue of the kinds of communities and conditions that they have to live in? Do you feel that this is one of the driving factors as it relates to this, any way to seek respect/recognition?

Ms. JACKSON. I think seeking recognition is an important element. Many young people feel that the fastest way to get on TV

is through Cops or America's Most Wanted and that is a very, very direct route, or the local programs that mimic those.

I was part of the alcohol prevention movement in the 1980's when the media and the alcohol industry and advocates and a whole range of people were called together and placed in a retreat center and couldn't get out to begin to work out, how do you change the way in which alcohol is communicated? How do you not have people come home and immediately get the cocktails on the soap operas? How do you no longer have the funny drunks in the TV programs?

After being locked up together for 3 days, the groups did begin to arrive at things that have resulted now in the alcohol industry advertising about responsible drinking, not drinking as much, teens not drinking, developing contracts with teens, and not having everyone that goes out drink together. I think that they have changed the way the media is doing their thing, changed the way advertising is doing theirs, and I think something like that might be helpful in this because a lot of it is communicated. The teens don't—and young people don't get this idea of immediate fame through crime accidentally. That is something that is promoted in our society in large part through our media, but also through our tolerance of violence.

Mr. PAYNE. Thank you. I think the point you brought out about communicating to the public the car seat, infant seats and seat belts in general and also about the health hazards of smoking, old movies showed a lot of the main characters smoking, but today you don't see that, so it is just a consciousness level.

Another thing that was very sad was that last year, the principal from, I think it was Thomas Jefferson High School in New York, testified that she attended a funeral when she was just a new principal at the school and when she got to the funeral parlor, she was the only person that was at the funeral other than an organist. And so this is almost unbelievable where we have become so desensitized to the trauma of violence; the acceptance of it is just becoming outrageous.

The question of handguns, do you feel that the Brady bill, which simply gives a 7-day waiting period, is reaching far enough or do you think, in your opinion, that more stringent gun laws should be implemented in this country?

Ms. JACKSON. I would like to see more stringent gun laws, however, I do not want to see young people locked up for carrying guns and then the guns then sold back into the community, back to people who might distribute them. I don't want that to be a criminal offense where they are then—they have a gun or are put into jail for years and years rather than—I would rather see the educational approach.

I want to see the guns taken away and out of their hands, but right now we see guns confiscated and then when there are enough of them, they are sold back to gun dealers, so there is a continuing cycle of guns being replenished in our society.

So I don't want to overly penalize the teens, although I am very, very fearful of what is going on, but I also realize that many adults are also committing the crime, and so I would like to see cir-

cumscription or some sort of tightening of the gun laws, but not at the expense of civil rights.

Mr. PAYNE. Thank you. Thank you, Mr. Chairman.

Mr. TOWNS. Thank you very much, Congressman Payne, and Dr. Jackson. I know you have to depart, so feel free to do so. We thank you so much for your testimony. We look forward to talking with you further as we try to do something about the problem of violence we now are confronted with. So thank you very, very much for your testimony.

Ms. JACKSON. Thank you.

Mr. TOWNS. At this time I would like to call on Mr. Green from Brooklyn, NY.

STATEMENT OF RALPH GREEN, GUNSHOT VICTIM AND STUDENT, BOYS AND GIRLS HIGH SCHOOL

Mr. GREEN. Good morning, Chairman Towns and ladies and gentlemen of the subcommittee. My name is Ralph Green. I live with my family in the Bedford-Stuyvesant area of Brooklyn, NY. I am a 16-year-old and a junior at Boys and Girls High School. I feel privileged to be able to share with you my feelings on "Violence as a Public Health Issue," and how one violent act has changed my life forever. I hope my testimony helps to bring relief to young people in my community and millions of other people, young and old, across the Nation who cope with violence every day.

A year ago, August 13, I lay on the streets bleeding to death. On that rainy night, a night I will never forget, my friend and I took bullets in our backs from another young man who shot us at random. When we took the bullets, many people felt them.

There was nothing good about getting shot, but my friend was more fortunate than me. In less than 30 seconds my life changed drastically. The bullet from a .38 revolver shattered my pelvis, ricocheted into my intestines, tore away a portion of my colon, burst my bowel into the abdomen, and severed the left branch of the aorta, and that was just the beginning.

I lost 5 liters of blood, more than the body can afford to lose. As I lay on the street, I wanted God to take me. I had no hope that I would see another day. But as you can see, He had other plans.

When I arrived at Kings County hospital, I felt numb. I thought I was paralyzed. The last thing I can recall of that night was my sister holding my hand. When I came out of ICU psychosis, I learned that 2 months had passed, school had begun, and people across the country knew about me.

I also learned that I had survived nine major operations, all averaging 10 hours each or more. At the time, I did not know I had five more to go. Those operations included four amputations, two abdominal surgeries and four remoldings. At least 10 surgeons under the guidance of Dr. Susan Talbert worked on me day and night. Those doctors had their hands full with other patients from the city's war zones. Most of them were gunshot victims. Many of them died.

In the hospital bed, I fought another kind of war. My immune system broke down. I was totally dependent for a while on the doctors and on the life support system. But what kept me going was thoughts of my family and football. I did not know my leg had been

amputated from the hip until several weeks after my last operation. My mother had the doctors take me off morphine.

I had known pain before, but not quite like this. Just to give you an example, the night before a big game 2 years ago, I accidentally dislocated my finger in practice. I braced myself and I had my sister pull it straight. I didn't scream because if my mother would have heard me, she wouldn't have let me play. I suffered the pain and eventually went on to score four touchdowns and caught two interceptions. I dealt with the pain because I did not want to miss any opportunities.

Football scouts were already coming to watch me play and I knew that even though I was considered to be good in baseball and on the basketball court, my victories on the football field would lead me to a college scholarship.

I just want you to know what I was about up until the time I got shot. How have I changed since the night of August 13? Being the independent type, I like to do things for myself. Now I am forced to slow up. Sometimes I can be impatient.

When I am alone in my room with my trophies and plaques, I have about 45, and posters of my favorite athletes, I look at them and sometimes I wonder, what would have happened to them had a bullet cut them down. And sometimes I ask, why me?

I keep going because I don't feel sorry for myself. And even if I wanted to, my friends wouldn't let me. I don't know where I would be without Frank Mickens, the principal of Boys and Girls High School and Janet Moore, the assistant principal.

The Hurricanes football team and all the high school coaches and all of the high school football teams throughout New York City, the Jets, my friends, my family, and many other people throughout the country are there for me. And I am for myself. I lift weights daily and go to as many games as I can.

In June when I was involved in the Special Olympics at Hofstra University, I competed in air rifling, disk throwing volleyball, high jumping and wheelchair basketball. I jumped 5 feet without a prosthetic my first time out. I won two golds, one bronze and one silver. I like winning. I can't accept losing. I don't want anyone's pity.

Right now I practice basketball with special wheelchair handicaps Mondays and Wednesdays at Brooklyn College. Next month, I will be in Florida competing in the Special Olympics again.

All of this is good and it may even ease the guilt from some people that might learn about what I lost. But when there is nothing that I can do, my heart just hurts when I look at people in the NFL running and scoring touchdowns up and down the field. But you know what? I have a lot of obstacles to climb over.

My first obstacle is that my wheelchair is retired, but so is my jersey number, No. 9. I am glad I did not lose my life. I survived, but we young people everywhere are paying a heavy price to survive. Even the cost to taxpayers is out of control. I realize it is more about doing what is right than it is about money. There is no getting around it. Violence costs a lot in dollars and cents and in human lives.

I would like to tell you what the incident on August 13, 1992, cost taxpayers. My care at the hospital cost well over \$1 million. Just think, a portion of that could have paid the tuition for future

doctors, future teachers, lawyers, Congress persons, and even Presidents.

Someone I know, a teenager, was shot in the neck and in the mouth the same time I went in the hospital. He is still in the hospital up to this day. I am fortunate. I ask how many million-dollar bullets will it take before someone wakes up? Are the gunshots loud enough? Someone said recently, "A child growing up is now exposed to the violence without pain, violence without recriminations, and even violence with humor."

When they see this at such an early age, you have a hard time blaming the kids for what has been created as an environment. Everyone knows that guns are the major cause of death for a young black person my age. They are imported from manufacturers who see them as simply a product. Gun manufacturers say that the Constitution protects them and protects their products. But profits are made when people are killed.

We all learned in elementary school about life, liberty, and pursuit of happiness. Do you believe the founding fathers meant for children to lose their lives, liberties, and chances for happiness just because someone wanted to make money? It is up to you, the U.S. Congress, to tell gun manufacturers they must be responsible to pay for the toll their products are taking on our neighborhoods and our Nation.

I learned at an early age that an ounce of prevention is worth a pound of cure. If you want to prevent heart disease, you eat right. If you want to lower your chances of cancer, you don't smoke. If you want to save the future generations of this country, you got to take the guns off the street. This is something you can do. This is something you must do because the future of the Nation depends on it.

I would like to thank Congressman Ed Towns for inviting me and everyone on the committee for listening to me. I would like to enter this written testimony into the record and with your permission, I would like to send other thoughts I may have in the future on this subject to be placed in the record, too. If you have any questions, I would be more than happy to answer them.

[The prepared statement of Mr. Green follows:]

10/30/93

**Testimony of Ralph Green, Witness,
Hearings on "Violence as a Public Health Issue"
Before the Subcommittee on Human Resources and Intergovernmental
Relations of the House Committee on Government Operations**

November 1, 1993

Good Morning, Chairman Towns, Chairman Conyers, Surgeon General Elders and Ladies and Gentlemen of the Subcommittee.

My name is Ralph Green. I live with my family in the Bedford-Stuyvesant area of Brooklyn, New York. I am 16 years old and a junior at Boys & Girls High School. I feel privileged to be able to share with you my feelings on "Violence as a Public Health Issue" and how one violent act has changed my life forever. I hope my testimony helps to bring relief to young people in my community and millions of other people -- young and old -- across the nation who cope with violence everyday.

A year ago, August 13, I lay on the street bleeding to death.

On that rainy night -- a night I will never forget -- my friend and I took bullets in our backs from another young man who shot us at random.

There is nothing good about getting shot. But my friend was more fortunate than me. In less than 30 seconds, my life changed drastically.

That one bullet from a .38 revolver shattered my pelvis ... ricocheted into my intestines ... tore away a portion of my colon ... burst my bowel into the abdomen ... and severed the left branch of the aorta. And that was just the beginning.

I lost 5 liters of blood -- more than the body can afford to lose. As I lay dying on the street, I wanted God to take me. I had no hope that I would see another day. As you can see, He had other plans.

When I arrived at Kings County Hospital, I felt numb. I thought I was paralyzed. The last thing I can recall of that night was my sister holding my hand. When I came out of ICU psychosis, I learned that two months had passed, school had begun and people across the country knew about me.

I also learned I had survived nine major operations -- all averaging ten hours each or more. At the time, I did not know I had five more to go. These operations included four amputations, two abdominal surgeries and four remoldings. At least ten surgeons under the guidance of Dr. Susan Talbert worked on me day and night. Those doctors had their hands full with other patients from the city's war zones. Most of them were gunshot victims. Many of them died.

In the hospital bed, I fought another kind of war. My immune system had broken down.

I was totally dependent, for a while, on all those doctors and on the life support systems. But what kept me going were thoughts of my family and football. I didn't know my leg had been amputated from the hip until several weeks after my last operation, when my mother had the doctors take me off morphine.

(More)

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I had known pain before. But not quite like this. Just to give you an example; the night before a big game, two years ago, I accidentally dislocated my finger. I braced myself and had my sister Monica pull it straight. I didn't scream because I didn't want my mother to hear me. She would not have let me play. I suffered the pain, and eventually went on to score four touchdowns in the end zone. I dealt with the pain because I did not want to miss any opportunities. Football scouts were already coming to watch me play, and I knew that even though I was considered to be good in baseball and on the basketball court, my victories on the football field would lead to a college scholarship.

I'm not bragging about myself. I just want you to know what I was about up until the time of the shooting.

How have I changed since the night of August 13? Being the independent type, I like to do things for myself. Now, I'm forced to slow up. Sometimes, I can be impatient. When I'm alone in my room with my trophies and plaques -- I have 45 -- and posters of my favorite athletes, I look at them and wonder what would have happened had bullets cut them down. Sometimes I ask, "Why me?"

I keep going because I don't like feeling sorry for myself. And even if I wanted to, my friends wouldn't let me. I don't know where I would be without Frank Mickens, the principal of Boys & Girls High School and Janet Moore, the assistant principal. The Hurricanes football team, all of the high school coaches and all of the high school football teams throughout New York City; the Jets, my friends, my family, and many other people throughout the country are there for me.

And I am for myself. I lift weights everyday and go to as many games as I can. In June, I was involved in the Special Olympics at Hofstra University. I competed in air rifling, disc throwing, volleyball and high jumping -- I jumped five feet without a prosthetic -- my first time out; I won two golds, one bronze and one silver. I like winning and I won't accept anyone's pity. Right now, I practice basketball with the special wheelchair handicaps, Mondays and Wednesdays, at Brooklyn College. Next month, I will be in Florida competing in the Special Olympics.

All of this is good, and it may even ease the guilt some people might have when they learn about what I lost. But there is nothing that can take away my hurt when I watch football and know that I may never be able to play again. If I can do all that I am doing now, imagine what I would be doing if my leg had not been blasted away. You see, I still have obstacles to climb over. But I'm working on them. My jersey number -- number 9 -- is retired, but so is my wheelchair.

I'm glad I did not lose my life. I survived. But we young people everywhere are paying a heavy price to survive. Even the cost to taxpayers is out of control. I realize it's more about doing what's right than it is about money. There's no getting around it. Violence costs a lot ... in dollars and cents and in human lives.

(More)

RG ... page 3

I'd like to tell you what that incident on August 13, 1992, cost taxpayers. My care at the hospital "cost well over one million dollars." Just think. A portion of that could have paid the tuitions of future doctors, teachers, lawyers, Congresspersons and Presidents. Someone I know - a teenager -- was shot in the neck and the mouth, the same week I was shot. I left Kings County in March of 1993. He's still in the hospital. I ask you ... how many million-dollar bullets will it take before someone wakes up? Aren't these gunshots loud enough?

Someone said recently -- and I quote ... "A child growing up now is exposed to violence without pain ... violence without recriminations ... even violence with humor. When they see this at such an early age, you have a hard time blaming these kids for what (has been) created as an environment." The person who said that is the head of the American Medical Association.

Everyone knows that guns are one of the major causes of death for black men my age. These guns are not made in my community. They are imported from manufacturers who see them simply as a product.

Gun manufacturers say that the Constitution protects them and their products. But profits are made ... while children die.

We all learned in elementary school about "life, liberty and the pursuit of happiness." Do you believe the Founding Fathers meant for children to lose their lives, liberties and chances for happiness ... just because someone wanted to make money?

In many neighborhoods across the country, young people are finding it hard to pursue happiness when they're busy ducking bullets. How can you learn to focus if you're caught up trying to survive while bullets whiz past your head? Two year old children know how to duck ... when to duck ... and where to duck. They know that bullets hurt ... and kill.

It is up to you, the United States Congress, to tell gun manufacturers they must be responsible for the toll their products are taking on our neighborhoods and our nation.

I learned at an early age that an ounce of prevention is worth a pound of cure. If you want to prevent heart disease you eat right. If you want to lower your chances of getting cancer, you don't smoke. If you want to save the future generations of this country, you take the guns off of the streets.

This is something that YOU can do. This is something that you MUST do because the future of the nation depends on it.

I would like to thank my Congressman, Ed Towns, for inviting me, and everyone on the Committee for listening to me. I would like to enter this written testimony into the record, and with your permission, I would like to send you other thoughts I may have in the future on this subject to be placed in the record, too. If you have any questions, I would be more than happy to answer them.

Mr. TOWNS. Thank you. Without objection, your entire statement will be included in the record and we will leave the record open for a number of days for additional information. Let me thank you very, very much for that moving testimony.

At this time I will call on Dr. Weist.

STATEMENT OF MARK D. WEIST, Ph.D., ASSISTANT PROFESSOR, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE, ACCOMPANIED BY SHARTAE EDWARDS, TRINA MYERS, SHAWN WALLACE, AND CHRISTOPHER WILLIAMS, BALTIMORE CITY SCHOOL STUDENTS

Dr. WEIST. Thank you, Mr. Chairman, Mr. Payne, other subcommittee members. It is a considerable honor to testify before this hearing.

I am Dr. Mark Weist, a clinical psychologist from the school mental health program of the University of Maryland. We provide therapy services to students in Baltimore, in elementary, middle, and high schools. I brought four adolescents with me from one of these high schools, Shartae Edwards, Christopher Williams, Trina Myers, and Shawn Wallace. After my statement, each of these adolescents will provide a statement and then we will entertain your questions.

An unprecedented level of violence is affecting the physical and mental health of youth in our inner cities. In Chicago, one survey found that 75 percent of adolescents had witnessed a shooting, stabbing, robbery, or murder. In Washington, a recent survey found that one-third of a group of fifth and sixth graders had witnessed shootings, and one-fourth had seen a dead body in their neighborhood.

These alarming statistics address only the observation of violence. Many additional children are being victimized. In the survey of youth from this city, one-fourth of the children reported being victims of muggings and 1 out of 10 reported being victims of shootings.

In our work with children in the city schools of Baltimore, most of the boys have been victims of bankings during which three to eight boys kick and punch the victim, often inflicting serious injury. Many of the girls have also experienced this form of gang violence. Moreover, up to one-third of the girls we treat have experienced some form of sexual assault.

Children and adolescents are affected by violence exposure and victimization in a number of ways. Many show classic symptoms of post traumatic stress disorder, such as having vivid memories or images of the violent incident, having nightmares, being hypervigilant and fearful of harm to themselves and others, being unable to sleep, and avoiding people and places that remind them of the trauma.

The ability to think clearly and concentrate is often impaired related to chronic fatigue, nervousness, and intrusive thoughts and images of the trauma. The result is often poor school performance, which leads to negative reactions from teachers and parents, increases feelings of depression, and worsens an already compromised self-concept.

Feelings of guilt following exposure to violence are common. Children worry that they should have done something to intervene or

should have provided better aid to the victim. Sometimes they wish that they were the victims. Abused children may feel that the abuse was their fault, that they deserved it. Sexually abused children often feel damaged and dirty, with their sexual identities potentially compromised for their entire life.

Some children and adolescents become disconnected from their feelings going about their daily lives in a kind of fog. Too many have lost hope for their futures and take frequent risks with their lives because they do not expect to live to see age 21.

Related to this hopelessness about the future, many urban youth live recklessly for today, and unfortunately, growing numbers are being enticed by the fast money and fast life of selling drugs. Central to this lifestyle is the use of weapons, which are easily obtained, increase feelings of power and sometimes self-esteem, and are perceived as necessary for survival.

A serious side of the violence problem for urban youth is that many must contend with multiple violent deaths of family members, friends, or acquaintances. For these children, thoughts of the person who has died become traumatic reminders of their violent death, which seriously disrupts the bereavement process.

I turn now to what we can do to address the psychological reactions of children and adolescents who have been traumatized by violence. Here, ensuring that these youth have access to mental health services is critically important. One way to increase such access is to provide therapy services in schools. This is a growing movement throughout the Nation.

In Baltimore, we now have around 30 mental health programs in elementary, middle, and high schools. In our University of Maryland programs, we have found that between 70 and 80 percent of the students we see have had no prior mental health contact. Thus, these school-based mental health services are reaching more youth through the reduction of barriers that typically exist for obtaining such services in the community.

Therapy with traumatized youth first focuses on encouraging safety, support, comfort, and rest for the child at home. Youth often feel the need to talk about the trauma, to share details with therapists, family members and friends, and such open discussion is usually necessary for recovery. After the details of the trauma have been openly discussed, therapists encourage expression of emotions and work to reduce feelings of guilt and self-blame.

The child is then assisted in developing coping strategies and in using social supports. Other approaches, such as training youth to handle conflict, teaching and reinforcing survival skills, and helping families to problem solve about ways to minimize violence exposure are used by therapists in treating traumatized children and adolescents.

I would like to now turn the discussion over to four adolescents who have experienced firsthand the effects of urban violence. Shartae, Christopher, Trina, and Shawn will each share with you their experiences and thoughts about violence. Shartae.

[The prepared statement of Dr. Weist follows:]

Violence and Urban Youth
 Testimony before the Subcommittee on Human
 Resources and Intergovernmental Relations
 Congress of the United States: House of Representatives

Mark D. Weist, Ph.D.
 University of Maryland School of Medicine

An epidemic of violence is affecting the physical and mental health of youth in our inner-cities. Most urban youth have been witnesses to some form of violence. In Chicago, one survey found 75% of adolescents had witnessed a shooting, stabbing, robbery or murder (Shakoor & Chalmers, 1991). In Washington, a recent survey (Richters & Martinez, 1993) found that one third of a group of 5th and 6th graders had witnessed shootings, and one fourth had seen dead bodies in their neighborhood.

These alarming statistics address only the observation of violence. Many additional children are being victimized. In the survey of youth from this city (Richters & Martinez, 1993), around one fourth of the children were found to be victims of muggings, and one out of ten to be victims of shootings. In our work with children in the city schools in Baltimore, most of the boys have been victims of "bankings" at one time or another, during which a group of 3 to 8 boys kick and punch the victim, often inflicting serious injury. Many of the girls have also experienced this form of gang violence. Moreover, up to one third of the girls we treat have been experienced some form of sexual assault.

Children and adolescents are affected by violence exposure and victimization in a number of ways. Many show classic symptoms of post-traumatic stress disorder such as having flashbacks of the violent incident or incidents, having nightmares, being hypervigilant and fearful of harm to themselves and others, being unable to sleep, and avoiding people and places that remind them of the trauma.

The ability to think clearly and concentrate is often impaired related to chronic fatigue, nervousness, and intrusive thoughts and images of the trauma. The result is often poor school performance, which leads to negative reactions from teachers and parents, increases feelings of depression, and worsens an already compromised self-concept.

Feelings of guilt following exposure to violence are common. Children worry that they should have done something to intervene to prevent the incident, or should have provided better aid to the victim. Sometimes they wish that they were the victims. Abused children may feel that the abuse was their fault, that they deserved it. Sexually abused children often feel damaged and dirty, with their sexual identities potentially compromised for their entire life.

Some children and adolescents become disconnected from their feelings, going about their daily lives in kind of a fog. Too many have lost hope for their futures, and take frequent risks with their lives because they do not expect to live to age 21.

Related to this hopelessness about the future, many urban youth live recklessly for today, and unfortunately, growing numbers are being enticed by the fast money, and fast life of selling drugs. Central to this life style is the use of weapons, which are easily obtained, increase feelings of power, and sometimes self-esteem, and are perceived as necessary for survival.

A serious side of the violence problem for urban youth is that many must contend with multiple violent deaths of family members, friends or acquaintances. For these youth, thoughts of the person who has died become traumatic reminders of their violent death, which seriously disrupts the bereavement process (see Pynoos & Nader, 1988).

I turn now to what we can do to address the psychological reactions of children and adolescents who have been traumatized by violence. Here, ensuring that these youth have access to mental health services is critically important. One way to increase such access is to provide therapy services in schools. This is a growing movement throughout the nation, and in Baltimore, we now have around 30 mental health programs in elementary, middle and high schools. In our University of Maryland programs we have found that between 70 and 80 percent of the students we see have had no prior mental health contact. Thus, mental health services are reaching more youth through the reduction of barriers that typically exist for obtaining such services in the community.

Therapy with traumatized youth first focuses on encouraging support, comfort, rest, and nurturance for the child at home. Youth often feel the need to talk about the trauma, to share details with therapists, family members and friends, and such open discussion is necessary for recovery. After the details of the trauma have been openly discussed, therapists encourage expression of emotions, and work to reduce feelings of guilt and self-blame. Emphasis is placed on normalizing reactions related to the trauma or loss. Therapists then begin to help the child or adolescent to recover by developing coping strategies, and using social supports. Other approaches, such as training youth to avoid, or assertively handle conflict; teaching and reinforcing survival skills; and helping families to problem-solve about ways to minimize violence exposure are used by therapists in treating traumatized youth.

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Ms. EDWARDS. Good morning, Mr. Chairman, Mr. Payne, other members of the subcommittee, my name is Shartae. I am 17 years old and I am a senior at Southwestern High School in Baltimore, MD. I plan to attend Morgan State University and major in child psychology.

I have had several experiences with violence. When I was just 10 years old, I saw a man being shot while sitting on my front steps. It was so close that I could actually see the sparks from the gun.

At age 12, I watched drug sales from my bedroom window and almost witnessed a murder. In that particular neighborhood, children couldn't go in their backyards because they were scared of getting caught in the crossfire.

This February, 9 days after I transferred to Southwestern, I was next to a friend of mine who was shot in her knee while we were returning home from a basketball game. She was just an innocent bystander.

A couple of years ago, I, myself, was involved in a few violent activities. I used to start fights. I carried knives. I cut school or didn't go at all. I started disrespecting my teachers and my parents and most of all, myself; and there is a few things that I really wouldn't care to mention. It got so bad that I was scared to come outside because I never knew who was after me.

Then one day it hit me that this is not what I wanted for myself. I wasn't ready to die yet and it is exactly what would have happened if I would have continued hanging with the people that I was with. I was shortchanging myself and I knew it.

I decided that I didn't have to be what everyone else in the neighborhood was. I wanted to be different. I wanted to make people proud instead of making people feel ashamed. Now when I see groups of people fighting over a territory that they have no claim to, it makes me sad because I know that their lives are going down the same road that I almost took. Everyone won't be as lucky as I was and it is sad to say that half of them won't reach their 18th birthday, but it is not entirely the fault of the children.

Children act on what they see going on around them. I saw violence, so I chose violence as a way of life and I am sure that is the case of many other teenagers. I feel that if you see the surroundings of these children, make their communities less violent, it will cut into the violence they deal with as young adults.

Dr. WEIST. Thank you.

Christopher.

Mr. WILLIAMS. Violence is a thing that is said to be a crime of superiority. Many times the thrill of being feared or making people fear you causes violence. Many youth carry guns not because it is protection, but because he or she is feared.

My name is Christopher Williams and I am one of many who are affected by violence. I feel that more youth are into being known for violent acts than acts of good among their peers. For as you walk to the bus stop, your life can be taken or held up for money and other earthly possessions.

I would like to talk to you about some of the things I have seen and experienced. I have seen people commit suicide off a 14-story complex. I have stood in a line of cross fires. I don't want to die, but it just might happen. I can't control life and death. I am

scared—it scares me to see a friend die, shot for no reason. I try not to worry about it, being shot, killed, but it just might happen. I don't like it. But I must move on.

Some people can't do that. They don't have enough willpower to do so. That is why we must help them, because like me, they have seen the reactions of a gun man. They have seen friends shot eight times for no reason whatsoever and lose our hope. They have seen people die for—they have seen people die for no reason whatsoever.

What can we do to stop the hate in America? We can't take away all the guns because for every two guns taken off the street, four more are put back on. If people cared about each other, the violence might decrease in our cities. Thank you.

Dr. WEIST. Thank you, Christopher.

Trina.

Ms. MYERS. Good morning. My name is Trina Myers, and I am a 17-year-old senior at Southwestern Senior High School in Baltimore, MD. After graduation I would like to major in mortuary science.

When I was 14 years old, my uncle was shot and killed when I was two blocks away from the scene. I saw someone brutally beaten with a bat and I saw someone else stabbed to death as a result of a drug transaction. I have seen countless numbers of gun and drug transactions. I have witnessed many counts of females attacked and physically abused.

I don't classify violence as an adolescence issue or a young people issue. I classify it as a society issue. I think society's main problem when it comes to situations that can lead to violence is a lack of communication.

What we fail to realize is if we took the same time arguing and fighting and sat down and tried to resolve the problem, most of the violent outcomes we have today would not occur. A lot of neighborhood problems we have are brought to school and that involves the rest of the student body and subjects innocent people to danger.

Also, parents don't get involved in school activities and events. A lot of problems could be resolved a lot easier with the help of our parents. If parents could get their children involved in some kind of extracurricular activities such as dance, Little League, a job, et cetera, that could cut down on the percentage of children in cross-fires, abductions, and neighborhood violence.

When children have too much free time, they tend to get into trouble. If city and State officials see their parents are sincerely involved in the stand against violence in schools and neighborhoods, they too will become more involved and get us more school police and more people to patrol our neighborhoods better, to keep it, them and us and our children safer.

Dr. WEIST. Thank you.

Shawn.

Mr. WALLACE. Hello. I am 17 years old, a senior at Southwestern High School in Baltimore, MD. My career goal is to become a Secret Service agent.

My most recent experience of violence was just last week when I saw a student hit another student in the head with an acorn when he was exiting the bus. To my surprise the student that was

hit jumped in the bus window and began to beat the student who threw the acorn savagely.

I have lost several close friends and relatives, to violent acts. Drugs and handguns have become a way of life for our youth. My cousin was gunned down by his best friend because he was jealous of a few material possessions that my cousin had acquired honestly.

My friend was murdered in a drug-related incident. It was a case of mistaken identity.

We must start our children out with a strong religious background, teach our children moral values and be aware of the activities that go on in their everyday lives. I think some type of government funding for adolescent counseling programs would also be a big help.

My mother once said she never did anything wrong at home or away from home because she never knew who was watching her. It is time for parents, teachers, community leaders and officials to start opening their eyes once more.

Thank you.

Dr. WEIST. Thank you, Shawn.

Mr. Chairman, Mr. Payne, we will entertain your questions.

Mr. TOWNS. Thank you, Dr. Weist, and all of the participants.

At this time I would like to call on Mrs. Daly.

STATEMENT OF MADELEINE DALY, WIDOW OF SLAIN BROOKLYN SCHOOL PRINCIPAL

Ms. DALY. My name is Madeleine Daly. I have been a widow for 10 months, 2 weeks and 1 day. My husband was Patrick F. Daly, the principal of Public School 15 in Brooklyn. He was killed in a cross-fire of a gang shoot-out in the Red Hook Housing Project. He was shot in the chest by a fatal bullet. This happened on a Thursday morning on the center mall of the project.

This area is the center courtyard of the housing complex. Residents use this mall to walk to and from work, stores, and Public School 15.

My husband often went into the project to visit families and to escort children home from school. This day he was looking for a child who left the school building after a fight with another student. He was concerned for the child's safety.

This is the day that has changed my life and the lives of my children. My son Patrick and my daughters Mary Elizabeth and Kathleen have been exceptional. They have conducted themselves with dignity all these months and at every function honoring their father. They have continued to do well in school. I know their father would have been proud of them. To the outside world, they present themselves very well. But I know they are hurting.

What do you tell children who can't understand the terrible pain they feel in their hearts? They have been forced to grow up very quickly.

This past Columbus Day was parent's weekend at my son's college in Albany, NY. Previously it had been a very special occasion for me. This year instead of my husband, my sister accompanied me. While we smiled and tried to be happy, we felt the emptiness and sadness.

As I looked throughout the campus and saw other families, I was consumed with grief that our family circle had been so violently broken and our lives so tragically disrupted. For my twin daughters, the celebration of their birthday will always be a reminder of this tragedy. Their father was buried on their birthday.

These events and others in my children's lives should have been happy memories. Instead, their hearts are filled with sorrow because of a bullet. There is nothing I can do to ease the ache in their hearts when I see the pain in their eyes. As a mother, it is frustrating to know your children are hurting and you can't soothe their pain.

For myself, my world has been turned upside down and I don't think it will ever be set right again. My heart is truly broken and overwhelmed with sadness. There is no one to share the accomplishments or problems of family life. I have assumed the tasks of my partner, tasks which were unfamiliar with me. It has been a struggle for me. But somehow I have kept going for the sake of my children.

Pat was my husband for 23 years, but more, he was my best friend and companion. We did everything together. Our marriage was an equal partnership, each complementing the other. We shared everything from the major problems of raising a family to the simple joys of taking an evening stroll.

Our plan was to raise our children, then enjoy the fruits of our labor while growing old together. Now I have all the responsibility. Nothing is enjoyable. And I will grow old alone.

The man I loved and who loved me was cruelly and abruptly taken away. None of us will ever be the same people we were before December 17, 1992.

After Pat was murdered, the media carried many accounts of his work in the Red Hook community. The stories barely touched the surface of his extraordinary life. He inspired and encouraged thousands to improve themselves. He directed them on to the right paths. He saved their lives. This I know to be true because of the large numbers of people who came forth with accounts of how Pat had dramatically influenced their lives.

I will never forget the children and the adults who came to the funeral home. The faces of the children were filled with pain for the man who had given them hope, who helped them solve their problems and live better lives. Who will help them now? He was always there when they needed him: patient, kind, diligent on their behalf, understanding and supportive. No one can take his place. No one could give as much to so many. In the 26 years he worked in Red Hook, he never made an enemy. No one has said an unkind word about him.

Just think for a moment of the thousands of children who will cross the portals of his school in the years to come. They will never have the benefit of his love and guidance. They will never learn about his quiet strength and devotion to their well-being. Under his guidance, Public School 15 had become a haven, a light shining in urban darkness. It is a place where children could feel safe, grow and feel good about the persons they could become. Mr. Daly was there. Everything was going to be all right.

I know that he would have continued to work in the community for many years. He loved being at his school and he loved the children.

They say from one candle many flames can be made to glow. Pat's flame has gone out and many flames will not glow because he is no longer with us.

Almost a year has passed since Pat's death and we continue to have victims being shot in our cities. This violence must stop. Take away the things that hurt the community: guns, drugs, fear and overcrowding.

Public School 15 was renamed the Patrick F. Daly School in honor of my husband. Create a community just like the Patrick F. Daly school, a haven from harm, where help, hope, and love are always offered.

[The prepared statement of Ms. Daly follows:]

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My name is Madeline Daly. I have been a widow for 10 months, 2 weeks and 1 day.

My husband was Patrick F. Daly, the principal of Public School 15 in Brooklyn, New York. He was killed in the cross fire of a gang shootout in the Red Hook Housing Project. He was shot in the chest by a fatal bullet.

This happened on a Thursday morning on the Center Mall of the project; this area is the center courtyard of the housing complex. Residents use this mall to walk to and from work, stores and Public School 15. My husband often went into the project to visit families and to escort children home from school. On this day, he was looking for a child who had left the school building after a fight with another student. HE WAS CONCERNED for the child's safety.

THIS IS A DAY THAT HAS CHANGED MY LIFE AND THE LIVES OF MY CHILDREN.

My son, Patrick, and my daughters, Mary Elizabeth and Kathleen, have been exceptional; they have conducted themselves with dignity all these months and at every function honoring their father.

They have continued to do well in school; I know their father would have been proud of them. To the outside world, they present themselves very well, but I know they are hurting. What do you tell children who can't understand the terrible pain they feel in their hearts? They have been forced to grow up very quickly.

This past Columbus Day was Parent's Weekend at my son's college in Albany, New York. Previously it had been a very special occasion for me. This year, instead of my husband, Pat, my sister

accompanied me. While we smiled and tried to be happy, we felt the emptiness and the sadness. As I looked around the campus and saw all the other families, I was consumed with grief that our family circle had been so violently broken and our lives so tragically disrupted.

For my twin daughters, the celebration of their birthday will always be a reminder of this tragedy; their father was buried on their birthday.

These events and others in my children's lives should have been happy memories, instead their hearts are filled with sorrow because of a bullet. There is nothing I can do to ease the ache in their hearts or the pain I see in their eyes. As a mother, it is frustrating to know your children are hurting and you can't soothe their pain.

For myself, my world has been turned upside down and I don't think it will ever be set right again. My heart is truly broken and overwhelmed with sadness; there is no one to share the accomplishments or problems of family life. I have assumed the tasks of my partner, tasks which were unfamiliar to me. It has been a struggle for me, but somehow I have kept going for the sake of my children.

Pat was my husband for 23 years, but more, he was my best friend and companion; we did everything together. Our marriage was an equal partnership, each complimenting the other. We shared everything, from the major problems of raising a family, to the simple joys of taking an evening stroll.

Our plan was to work, raise our children, then enjoy the

fruits of our labor while growing old together. Now, I have all the responsibility, nothing is enjoyable and I will grow old alone. The man I loved, and who loved me, was cruelly and abruptly taken away. None of us will ever be the same people we were before December 17, 1992.

After Pat was murdered, the media carried many accounts of his work in the Red Hook Community; the stories barely touched the surface of his extraordinary life. He inspired and encouraged thousands to improve themselves. He directed them onto the right path. He saved their lives. This, I know to be true, because of the large numbers of people who came forth, with accounts of how Pat dramatically influenced their lives.

I will never forget the children and the adults who came to the funeral home. The faces of the children were filled with pain for the man who had given them hope, who helped them solve their problems, and live better lives. Who will help them now? He was always there when they needed him when they needed him; patient, kind, diligent, understanding and supportive. No one can take his place. No one could give as much to so many. In the 26 years he worked in Red Hook, he never made an enemy. No one has said an unkind word about him. Just think for a moment of the thousands of children who will cross the portals of his school in years to come. They will never have the benefit of his love and guidance. They will never learn about his quiet strength and devotion to their well being. Under his guidance, Public School 15 had become a haven, a light shining in urban darkness; it is a place where children could feel safe, grow, and feel good about the persons

they could become; Mr. Daly was there, everything was going to be all right. I know that he would have continued to work in the community for many years. He loved being at his school and he loved the children. They say, "From one candle many flames can be made to glow"; Pat's flame has gone out and many flames will not glow because he is no longer with us.

Almost a year has past since Pat's death, and we continue to have innocent victims being shot in our cities. This violence must stop.

Take away those things that hurt the community: ILLEGAL GUNS, DRUGS, FEAR and OVERCROWDING.

On May 27, 1993, Public School 15 was renamed "THE PATRICK F. DALY SCHOOL" in honor of my husband.

Create a community just like "THE PATRICK F. DALY SCHOOL", a haven from harm where help, hope and love are always offered.

Mr. TOWNS. Thank you very much, Ms. Daly, for your testimony. It is very moving testimony. I think that when we listen to all the witnesses, it points out more and more that this is a public health issue, and that we must address it as a public health matter.

Let me begin, Dr. Weist, by first asking you, do you agree with Dr. Jackson that many of the youth in your program experience violence at such an early age that we are just now seeing evidence of that exposure once they reach high school?

Dr. WEIST. I agree with that, Mr. Chairman. The effects of trauma can be carried on for years, well into adulthood, and so many of the children that have been traumatized earlier in their lives are still carrying around evidence of that trauma today. Unfortunately, the problem seems to be worsening. So the future generation is at particular risk.

However, even adolescents who have experienced a great level of trauma in their life can still be helped, and can still recover from that trauma.

Mr. TOWNS. What kind of resources has the public school system in Baltimore been able to provide to support your programs? What have they done to support you?

Dr. WEIST. It is a cooperative program between the Department of Education and the Department of Health in Baltimore City, and the resources have increased in recent years. The program has shown steady growth since its inception.

The mental health programs began back in 1988, with six schools having mental health clinicians. Each year we have added a number of schools and, as I mentioned, we are up to around 30 schools, and I would expect we would be expanding the program in the future.

Mr. TOWNS. One other question, very quickly. Health care reform is a big issue around here now, everybody is talking about it. What should we do under health care reform to support school-based programs like yours? Because we recognize that this is a very serious problem, and it must be addressed.

Dr. WEIST. I think a number of steps should be taken. Coordination of efforts that are going on across the country would be an initial step. There are pockets of efforts in various cities where school mental health services are being offered.

A beginning step would be organization of a conference to get these people together. Beyond that, prioritizing funding for school-based mental health services would be critical.

At present, many of the clinicians operate on their own. They don't have a support team, so to speak. We have submitted proposals to increase staffing in the schools. But they are only at the proposal stage.

We could use clinics in each one of these schools, versus a single clinician. So privatizing funding mechanisms to create these programs would be, I think, the most important step.

Mr. TOWNS. Thank you very much.

Let me just sort of raise this with the young people. When we talk about TV violence, of course, it was talked about by Dr. Elders. Of course, my colleague, Donald Payne, raised it, and of course I have talked about it myself.

Television violence, do you think that it plays a role in terms of people playing out some of these things that are going on? I would like to hear from the young people. Why don't we start with you, Ms. Myers.

Ms. MYERS. It plays an important role. In our cable television, we have various channels that air videos, music videos, and what we, as adolescents, fail to do is sit down and actually listen to the music that is being played. And most of our rap songs, which is a big hit with teenagers, you hear all kinds of songs about shooting, stabbing, disrespecting females, anything that has to do with drugs and violence, with cars.

A lot of our movies that are played today that are promoted by us, we go, and they are million-dollar sell-outs, with violence and a lot of shooting and killing. Most of our cartoons in the morning, such as Super Heroes, are loved by children but they also have a large percentage of violence in it.

And I think it is playing a big role because as children, they are seeing this on television and they feel that it is a way of life; this is the way it is supposed to be. And a lot of parents don't take the time to sit down and talk to their children and tell them, This isn't the way it is supposed to be.

Mr. TOWNS. Mr. Green, I want to just raise a question with you. You indicated that your medical care cost over \$1 million. And when I look at that, I sort of think about how much we can do with that, in terms of supporting a program like Dr. Weist has just talked about, and sort of conveying it at an early age, to young people, that violence is not the way to go. So I think that when you talk about the cost of your care, I think that somewhere along the line we have to try to get that message across.

And I would like to personally thank you for coming and saying it in a way that everybody can understand it. So if you were a Member of Congress for 1 day or 2 days or for 1 week, or forever, what would you recommend that I do?

Mr. GREEN. Well, if I was a Member of Congress, I would recommend that you try your best to keep the guns off the streets, because that is taxpayers' money, going into the hospitals and stuff. So the less guns, less shootings, less people in the hospital, that is more money. And New York City won't be in a deficit.

Mr. TOWNS. Thank you.

Ms. Daly, I know of the great work of Mr. Daly, of how he is respected in the community, and in the process of trying to help someone, he lost his life. I have heard the stories of the young people in the area talking about all the great things he has done for them, and the fact that many of them at the college level indicated he would not have made it if it had not been for his support and encouragement.

I look at all the positive things they are saying and then I look at you in terms of trying to carry on, and I think that is very positive, in every sense of the word.

What recommendations and suggestions do you have for this committee as to what we might be able to do to prevent situations like this from recurring in the future?

Ms. DALY. Perhaps we should start with the very young children and develop a strong self-esteem, that they feel good about them-

selves, that they develop an inner peace within themselves, give them hope that they can become whatever they choose, and then maybe go to the young parents-to-be, and tell them and instruct them on how important it is to be a parent, how they have to guide their child.

And this child is their responsibility for many years, not only when the child is 1 or 2 or cute, but as the child gets older and has larger problems. Maybe we need agencies to help young parents to deal with the children as they get older, to guide them and instruct them.

The school has to be a haven, like my husband's school, a place where the children want to go, a beautiful place that is well kept and well cared for, and the people at the school care about the children.

My husband was instrumental in keeping the school open until late at night, to have programs for the children, sports programs, homework programs, to keep the children off the streets and away from the drug dealers.

Mr. TOWNS. Thank you very much.

At this time I would like to yield to my colleague, Congressman Payne.

Mr. PAYNE. Thank you very much.

Thank you, panel, for some very moving testimony that we have heard here this morning. I would like to once again thank each of you for your participation.

Dr. Weist, as it was stated earlier, we as a society seem to be adopting and accepting violence as a formal behavior. Can you describe the psychological implications of the culture of violence in today's youth?

Dr. WEIST. Yes, I touched upon some of the aspects of psychological effects of kids that have been traumatized by violence. A major component is just being traumatized, of living in a state of perpetual anxiety, fearing that violence will happen at any minute to oneself or to a family member or friend, feeling like there probably will not be a future, feeling like "tomorrow I could die."

So there is a very high level of nervousness, anxiety, and fear. There is also a very high level of depression associated with so much loss. So many of the kids that we work with have had multiple deaths occur to family and friends by violent means.

The problem is often one of, you can't recover when things continue to happen. When you have been traumatized and there continue to be small traumas in your life, when there is a rumor that a child in your school has a weapon, when three boys threaten to beat you up, when someone pushes you in the hallway, when your mother gets stuck up on the way home from work, it really impedes recovery from trauma.

That is such a significant issue for many of these kids, that when they begin to recover from some violent incident, something else happens to set them back. That contributes to their sense of futurelessness: "I don't have a future; why should I invest in society when I am not going to be able to contribute to society."

Mr. PAYNE. I guess following that, then, you feel that that certainly would have an impact on a student's interest in the future, for example, in education, later their children, when they become

adults and get to buy a house and have children; instead they would tend to live for today because tomorrow may not come, and therefore careless behavior, whether it is sex, whether it is violence on someone else, whether it is taking, as I indicated, some youngsters decided to see who can drive cars backwards faster through even intersections against the light. This is certainly I guess symptomatic of the fact that "I may not be here; let me just have some thrills."

Would you concur with that?

Dr. WEIST. Yes, I would. It is very hard to see a future life of comfort and safety that many of us have experienced. And much more salient for these kids are the drug dealers driving around in their Lexus cars and their Legends and having lots of money and appearing to have something going for them. So the lure of that I think is increased when you are so fearful for your own safety and are very pessimistic about your own future.

Mr. PAYNE. Finally, I have introduced legislation, I am a member of the Education and Labor Committee, which is the Elementary School Counseling Act, where we are attempting to have funded some demonstration projects around the country wherein elementary school counseling would be there. And just because of the trauma associated with increasing violence in schools and situations like that, do you think that that type of legislation would be very important?

Dr. WEIST. I think that would be critical. I think school-based services are very important at all levels. I think the case can be made that we begin at the early levels to try to prevent some of the outcomes of violence, try to prevent kids from becoming violent, or becoming so traumatized that it is hard for them to recover.

But I also do believe we should have those services at all levels, elementary, middle, and in high schools.

Mr. PAYNE. Finally, in our city, we recently—I am a former member of the municipal council before coming to Congress, and Mr. Harris recently passed an ordinance banning the sale of T-shirts depicting profanity, and degrading images of women, and they are just being sold up and down the street.

Do you feel that there is a lack of responsibility on the part of commercial people, in addition to television violence and movie violence, but for a manufacturer to manufacture and a peddler to sell these kinds of things?

Of course, there is going to be a question about the constitutionality, the first amendment. But I commend the municipal council in Newark for passing an ordinance and just taking it to the courts.

Do you feel that has a negative impact on our students?

Dr. WEIST. I agree. I think anything that glamorizes violence or says it is OK to put others down is a stimulus that could provoke violence. I would support efforts to eliminate those stimuli.

I know in Baltimore City we have efforts under way to take down billboards that promote alcohol use in the inner city. I think those efforts are needed as part of a comprehensive plan to begin to address this problem.

Mr. PAYNE. Let me just conclude, try to conclude by asking the young people, for the past 3 years, during the Congressional Black

Caucus, that is 4 years, actually, I have conducted a brain trust. I chair up the youth brain trust, and last year the brain trust was called "Reaching the Hip-Hop Generation." We discussed ways to try to communicate with young people because we were trying to figure out how we could get a message to young people and to try to listen to them. We know that just saying don't do something is not enough.

But I want to pose a question to each one of you. How can we get to today's youth, in your opinion, get them to understand that violence is harmful, drugs are harmful? Up to now evidently we have been unable to communicate effectively. Do you think we are using the wrong kind of media, the wrong PR consultants the wrong message?

I would like to hear how you would do it if you had an opportunity.

Mr. Green.

Mr. GREEN. I think that you should try different things besides songs, because if a kid in the streets, in Brooklyn where I am at, hears a song about school, they don't want to hear about that. You should have basketball tournaments, where people are involved, boys and girls. That is what I think it should be, tournaments, stuff like that is correct because the average kid out there don't want to hear a song about education and stuff like that.

Mr. PAYNE. Any of the others with any suggestions on how you would try to communicate to your peers, your classmates, if you had a chance to do that?

Mr. WALLACE. Another way to do it would also be to show them the other side of violence, the results of violence, and make statistics more available to people our age so they can see what is going on, and show them it is not so glamorous, and then on the other hand present things as glamorous—I mean, show them another way to have glamorous things without going through violence or illegal activities to get them.

Mr. PAYNE. Thank you.

Any others?

Mr. WILLIAMS. We need to show the youth of today that they can get a job without having to sell drugs, be rich without having to do the stuff that people are doing on the street. We need to make it so they have fun while they do it. Because it is like children that see violence tend to be more violent. But if you keep them playing football games, basketball, baseball, they tend not to be violent. They tend to care about sports and academic stuff, because you need academics to stay in school. That way, they can go to college and make something of their lives.

Mr. PAYNE. Thank you.

Ms. EDWARDS. Also, I feel that if you have more positive role models in the communities, and they were supporting for them to better themselves instead of resorting to violence, then it would also help them to get the point that violence is not the answer, and also community functions, because people are not coming together. People feel if it is not particularly, you know, pertaining to them at that point, then they don't want to be involved. If they can come together, then maybe they can help stop what is going on.

Mr. PAYNE. Let me just ask you, is that what happened to you? You said you were doing the wrong thing, you didn't care, but then one day you decided to change. Would you be able to tell us why, unless it is too personal?

Ms. EDWARDS. It is because I changed over, started going to church, giving time to God, and realizing the things I was doing weren't going to better me, it was only going to make things worse.

Mr. PAYNE. Thank you.

I would like to say to Ms. Daly, I really appreciate your coming and testifying, as the chairman said. I do feel that the death of your husband will not be in vain. I think that people around the country, attention is drawn to the fact that this violence is out of control. I think it is happening all around, and there has been no real focus on it. But this hearing tended to put a focus on the question of violence in our society. And now I hope that we can come up with some solutions.

Thank you.

Mr. TOWNS. Thank you very much, Congressman Payne.

Let me also indicate the fact that I appreciate all of you coming and sharing your experiences with us, and of course I think the one thing that you have clearly pointed out is that a positive involvement will make a difference. I really feel that we need to focus on that and to try to find the resources to encourage young people to get involved in a very positive way.

I think if we are going to talk about health care reform, somewhere along the line we have to think about finding some money to put in there to make certain that we are able to give young people that kind of positive kind of involvement and direction.

There are all kinds of areas where you find something at some level that a young person can do and be able to do it effectively.

So let me thank all of you again for sharing those experiences with us. I think it will mean a great deal as we deliberate in terms of our health care package and all the other things we might do here in the Congress.

Thank you, Mr. Wallace, Ms. Myers, Ms. Daly, Mr. Green, Mr. Williams, Ms. Edwards, and of course Dr. Weist. I also appreciate your testimony as well. Thank you very, very, very much. Thank you.

Our second panel, Dr. Kellermann, who has just completed a study on violence, and Dr. Stanton, who has done research on youth violence in urban areas. If you would take your seats. Let me thank both of you for coming to testify.

Why don't we begin with you, Dr. Stanton.

STATEMENT OF BONITA STANTON, M.D., PROFESSOR, DEPARTMENT OF PEDIATRICS, AND DIRECTOR OF THE CENTER FOR MINORITY HEALTH RESEARCH, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Dr. STANTON. Thank you.

Good afternoon, Mr. Chairman, members of the subcommittee. I am Dr. Bonita Stanton, professor of pediatrics and director of the Center for Minority Health Research at the University of Maryland School of Medicine. I appear this afternoon on behalf of the Asso-

ciation of American Medical Colleges, which speaks for 126 U.S. medical schools.

As a result of decades of research and experience, U.S. health care providers possess a wide range of lifesaving technical skills to offer victims of violence. As physicians, many of us are highly skilled in effective treatments to repair the acute physical effects of violence, such as setting bones and suturing lacerations.

However, both as health care providers and as educators, we have another series of important missions. We know that victims of violence and their families have a strong likelihood of future victimization by violence, and as we have heard all morning, the untold consequences of the violent act may go on for years.

Medical school faculty must train medical students to be effective, not only in treating the immediate physical effects of violent behavior, but also in treating the long-term rehabilitative and preventive needs of these patients in order to address the broader public health issues of violence.

Three main factors are involved in accomplishing this expanded teaching mission. First, we must sensitize medical and other health professional students to a broader professional obligation to victims and perpetrators of violence.

Second, students must recognize and respect the sociocultural diversity that can be associated with violence.

Third, students must know what support services should be available to both victims and perpetrators of violence.

Traditional medical school curriculums provide an excellent biomedical basis for addressing the acute injuries of trauma. Of equal importance, but in recent years receiving much less emphasis in medical schools, is the training of students to address health issues beyond the direct immediate and physical concerns of the patient.

Recently many medical schools have begun to implement programs which orient students toward this second, broader obligation they must address as physicians. For example, most medical schools have incorporated educational experiences in violence-related health issues such as substance abuse, domestic violence, et cetera.

These curriculums changes require funding both for their development and implementation, and also for evaluation in order to monitor their effectiveness.

The second impediment to effective intervention in assisting victims of violence relates to sociocultural barriers that all too frequently exist between physicians and victims of violence. These differences in cultural and economic backgrounds minimize the likelihood that without appropriate training and experience, physicians will be skilled in detecting high risk patients, in treating them effectively, and in enrolling them in appropriate services.

Historically, issues and cultural diversity have received minimal attention in the medical curriculum. However, the situation has begun to change. Much of the research undertaken by my colleagues and me is directed at this issue. Other campuses are beginning to adopt curriculums based on existing models of cultural diversity to address their local needs.

Finally, the third factor necessary to enable medical students and physicians to address the broader issue of violence is sufficient

support services for victims and perpetrators of violence. A lack of service options is a problem in itself, but also creates a larger systemic problem.

As physicians, we learn with time what questions not to ask our patients. If we cannot address a problem, we learn how to stop ourselves from seeing that problem and how to subtly guide our patients to cover that problem from us.

This training is not any part of an explicit curriculum but results from a paucity of adequate referral and support services in our communities.

Instead, one of our goals as educators should be to make our students patient advocates in general, including becoming advocates for community services for long-term solutions, such as many of the suggestions we have been hearing all morning. What kind of services are we discussing?

For the adolescent age group, services should include first-time offender jobs training options, alternative educational options and employment and placement support. Included in these programs, which address the economic and educational sources of violence, should be training and decisionmaking and interpersonal negotiation.

Radical expansion of these programs, which have been shown to work, and greater analysis of their health impact to guide their further development, is urgently needed. Physicians must be trained about these treatment options and must learn that placement of their patients in appropriate programs can be as essential to the practice of good medical care as is the performance of any required biotech procedure.

The Federal Government and academic medical centers have an opportunity and an obligation to significantly alter the role violence is playing in our society. We must assure that adequate treatment services are available in communities to enable our graduates to provide high-quality health care and to serve as patient advocates. We must teach them that patient advocacy is an essential role of the physician, and society must learn to value this role of the physician.

In addition, service and research funds directed at violence, treatment and prevention should be linked. In this way, we can build upon what we already know, expand our knowledge base of what works, and begin to identify the relative value of various program options.

Thank you very much for this opportunity to testify today. And I would be happy to answer questions or expand.

Thank you.

[The prepared statement of Dr. Stanton follows:]

STATEMENT

OF THE



ASSOCIATION OF
AMERICAN
MEDICAL COLLEGES

Robert G. Petersdorf, M.D., President

THE HEALTH EFFECTS OF VIOLENCE: THE RESPONSE OF MEDICAL EDUCATION

Presented by:

**Bonita Stanton, M.D.
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Submitted to:

**Subcommittee on Human Resources and Intergovernmental Affairs
Committee on Government Operations
U.S. House of Representatives**

Edolphus Towns, Chairman

**Monday, November 1, 1993
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Good morning Mr. Chairman and members of the Subcommittee. I am Dr. Bonita Stanton, professor of pediatrics and director of the Center for Minority Health Research at the University of Maryland School of Medicine in Baltimore. I appear this morning on behalf of the Association of American Medical Colleges (AAMC), which serves as the national voice for the 126 U.S. medical schools, over 400 major teaching hospitals and 90 professional, academic societies.

As the research paper attached to my written statement and other witnesses have indicated, a great deal of research has equipped physicians and other health care providers to recognize and intervene on behalf of victims of violence. In the emergency room and primary health care settings we see victims of violence and youths with a history of violent behavior on a daily basis. We are familiar with effective treatment to repair the effects of violence, such as setting broken bones and suturing lacerations. We also know that the individuals we treat have a strong likelihood of future victimization as do their family members.

As educators, we have another series of important missions. In other words, how do medical school faculty introduce physicians-in-training to material that enables them to identify and treat victims of violence, to refer these patients to appropriate social services, and to address the public health issues of violence. Three main factors are involved:

1. We need to sensitize students in their professional approach to victims and perpetrators of violence.
2. Students must understand the socio-cultural diversity that can be associated with urban violence.
3. Physicians must be aware of what support services should be available to both victims and perpetrators of violence.

Medical students see manifestations of the health effects of violence on a regular basis. Traditional medical school curriculum provides an excellent biomedical basis for addressing patients with acute conditions and trauma. In addition, medical schools have made progress in implementing innovative programs to teach young physicians to address health issues beyond the direct and immediate medical concerns of the patient. Such programs are intended to help students identify and take steps to alleviate the systemic bases of medical problems caused by violence. For example, the vast majority of medical schools have incorporated educational experiences in violence-related health issues, such as course content in substance abuse, domestic violence, medical jurisprudence, as well as death and dying. These educational experiences are examples of efforts underway to sensitize students to the process of a comprehensive approach to patient needs. These type of curricular changes require funding, both to make the adjustments, and, as important, to monitor their effectiveness.

The second impediment to effective intervention in assisting victims of violence relates to a socio-cultural barrier that often exists between physicians and the patients we have been discussing today. The differences in cultural and economic backgrounds of the majority of

health care providers and victims of violence minimize the likelihood that, without appropriate training and experience, physicians will be skilled in detecting high-risk patients, in treating them effectively, and in enrolling them in appropriate services. Historically, issues in culture diversity have received minimal attention in the curriculum. This trend has begun to change. Much of the research undertaken by my colleagues and me is directed at this specific issue. Other campuses have made efforts to adapt existing models to meet their local needs.

The final critical factor I mentioned is the fact that most communities do not have sufficient support services for victims of violence and individuals who exhibit violent behavior. A lack of service options is a problem in itself, but also creates a larger problem. As physicians we sometimes learn what questions not to ask--if you cannot help, do not raise false hope. The paucity of referral services creates a larger problem because it deters physicians from asking important questions. As a result, it undermines the effectiveness of efforts to implement appropriate curriculum content and culturally sensitive programs.

As in the other areas I raised, there are excellent model programs that can be adopted. Most medical schools have electives which expose students to community-based primary health care. Through such community-based programs, potential victims and perpetrators of violence can be identified proactively and steered toward appropriate services. While examples of demonstration and model programs abound, few if any medical schools have adequate access to appropriate referral services for all potential victims of violence. As a consequence, we teach our students to identify and treat the problem, but offer them few options for assisting in facilitating a long-term solution. One of my goals is to make my students patient advocates in general, including becoming advocates for community services directed at long-term solutions.

We speak frequently of the need for training more primary care physicians. Primary health care training is the center for violence prevention and should be the center for training of long-term care of victims of violence. Long-term care should not be restricted to the care of those who remain physically handicapped by an episode of violence. Just as we have learned that a high lead level in a child requires investigation and action in the child's life, so too we must train physicians and equip them accordingly, that an act of violence requires further investigation and probable long-term rehabilitative support. Case-management and managed care have become popular terms. They only work if the resources and programs exist and physicians and other professionals provide patients access to these services.

What kind of services are we discussing? For the adolescent age group, essential options are first-time offender jobs-training, alternative education, and employment placement and support. Included in these programs, which address the economic and educational sources of violence, should be seminars in decision-making and interpersonal-negotiation. These can be offered in the health services setting, the community or on the job. Preliminary research suggests that such programs work well. What is needed is further expansion of the programs and greater analysis of their health impact--do they prevent future injuries due to violence? Victims of violence and those who witness violence may also require

mental health services for post-traumatic shock. Failure to address this need is associated with severe depression and ultimately, higher rates of violence. Physicians should be trained about these treatment options and to understand that placement of their patients in appropriate social service programs is as essential to quality health care as referrals to appropriate sub-specialists.

The federal government and voluntary agencies, including academic medical centers, together have a chance to alter and improve the tragedies caused by violence. We need to provide leadership to assure that the services are available in communities to enable our graduates to provide high quality health care and to serve as patient advocates. In addition, service and research funds directed at violence treatment and prevention should be linked. In this way, we can build on what we know, what is being done currently, and ultimately begin to identify the relative value of various program options.

Thank you for the opportunity to testify this morning. I will be happy to expand on my remarks or answer questions.

Violence and drug-trafficking among urban youths

Prepared by Bonita Stanton, M.D., Jennifer Galbraith, M.A., Lisa Horton, M.D., Anna Gadomski, M.D., Linda Kaljee, M.A., and Izabel Ricardo, Ph.D.

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Introduction

Violent crime has increased substantially in the United States in the last decade. Homicide has become the leading cause of death among African American males and females between the ages of 15 and 34 (CDC, 1986; CDC, 1990). From 1984 to 1987, homicide rates among African American males ages 15 to 24 increased 39% and among 15 to 19 years, 53% (CDC, 1990). Ninety-five percent of this increase was associated with firearms, which now account nationwide for 81% of all homicides (Roper, 1991). There is also a high rate of homicide among other minority groups. The homicide rate for Native Americans and Hispanics is 2 and 3 times higher respectively to that of whites living in the same regions of the country (CDC, 1986; IHS, 1990).

Concomitantly, many minority youths witness acts of violence. In a survey conducted among children residing in "inner city" Chicago, 17% of the youths reported having witnessed a homicide, 26% a shooting, and 29% a stabbing (Roper 1991). In two recent national surveys of youths aged 11 to 14 (Millstein 1992) and those in grades 9 to 12 (CDC, 1991), one fifth of youths reported having carried a weapon for protection.

There is widespread consensus that this problem of violence, particularly that among impoverished urban areas, demands immediate intervention. Where there is less certainty is how best to intervene. Development of potentially effective intervention efforts will require greater understanding the factors leading to the violent behavior. Widescale implementation of intervention programs should be undertaken only after it is determined which interventions are effective in reducing violent behavior and can be linked to improved health outcomes, such as reductions in mortality and permanent disabilities, and lowered health care costs.

The causes and antecedents of violence are manifold. It is the purpose of this document to address one contributing behavior, drug-trafficking, which both appears to be of great significance in the etiology of urban violence and homicide and which has received relatively little analysis to date.

Drug-trafficking --the selling or delivering of drugs-- by minority youths in urban areas has received considerable publicity by the mass media in the last half-decade. Detailed descriptions of the violence, the significant health and legal consequences suffered by involved youths and their families (Meddis 1989; Bowman 1989; Roberts 1990), and the decreasing age of participants have been a central feature of this coverage (Shane 1992). However, there has been correspondingly little exposition of this problem in the scientific literature. Accordingly, this review will summarize the data linking drug-trafficking with violence and homicide, provide an over-view of the practice of drug-trafficking among youths, and describe factors associated with drug-trafficking to provide direction for future research and intervention efforts.

Mortality and drug-trafficking

Evidence implicating drug-trafficking in homicide, particularly in recent years, is compelling. Perhaps the most detailed investigation of this relationship was an analysis of homicides committed during 1988 in New York City (Goldstein 1990). This study analyzed prospectively all homicides committed between March and October 1988 in 17 of the New York City Police Department's 75 precincts. The precincts were selected in an attempt to be representative of the socio-economic, racial, and ethnic groups comprising New York.

Four-hundred fourteen homicide events were included in the study (one-quarter of the 1,896 homicides occurring overall in New York in 1988). There were 490 perpetrators and 434 victims. Eighty-three percent of the perpetrators were African-American and 95% were males. Causality was determined by both the police and the researchers according to pre-established definitions. Final classification as "drug-related" required independent concurrence by both the police and the researchers; otherwise the cause of the crime was described as "uncertain".

One-hundred seventy-nine (43%) of all homicides were a result of drug-trafficking. The most common issues precipitating the ensuing fights were territorial disputes, robbing of the drug-dealer, and assaults to collect debts. An additional 39 homicides (10%) were related to other aspects of substance abuse (ie., robbery to obtain funds to purchase drugs, irrational behavior resulting from intoxication). One-hundred forty (29%) of the perpetrators were drug-traffickers and 148 (34%) of the victims were drug-traffickers.

Less conclusive but supportive data of the association between drug-trafficking and homicide is available from other cities. For example, in Baltimore, of the 522 homicides committed in 1990, 166 (31%) were attributed to violation of "narcotics drug laws" (e.g., drug-trafficking). (Md Uniform Crime Report 1990).

To summarize, there is strong evidence that drug-trafficking is highly correlated with homicide. The strength of this association is in marked contrast to the putative association between drug-use and homicide; in spite of decades of research efforts, this relationship remains suggestive but inconclusive (Goldstein 1990).

Epidemiology of adolescent drug-trafficking

Given this significant relationship between drug-trafficking and homicide, a greater understanding of the epidemiology of this phenomenon and other associated factors is necessary to design potentially effective interventions. Population-based data regarding drug-trafficking is scant. Questions about drug-trafficking have not been included in any of the several national substance abuse surveys. However, results from several community and school-based studies enable a preliminary description of the

prevalence of the problem.

Five surveys assessing drug-trafficking among early adolescents are utilized for this review: two community-based, two school-based, and one multi-source cross-sectional survey which addressed drug-trafficking among youths. The two community-based surveys were conducted among youths 9 to 15 years of age residing in or near several public housing developments in Baltimore, Maryland in 1992 (n=455, Stanton, 1993; Li, submitteda) and in 1993 (n=351, Li, submittedb). In the 1992 survey, 8% of the youths reported having participated in drug-selling and/or delivering, (11% of males and 7% of females). In the 1993 survey, 6% of youths had engaged in drug-trafficking, with males (11%) being substantially more likely to have participated than females (1%) ($p < .00008$). Increasing age was highly correlated with participation in both the 1992 and the 1993 studies. Among the youths 13 to 15 years of age, 15% reported have been involved in drug-trafficking in the 1992 survey and 14% in the 1993 survey.

In the 1993 survey, youths were also asked how likely they thought they it was that they would become involved in the future. Twelve percent of youths perceived themselves as likely to become involved in drug-trafficking in the next six-months.

A similar picture was obtained from a school-based survey conducted among 7,573 youths attending 6 and 7th grade and 5,373 youths attending 7th and 8th grade in Washington D.C. (Bush, submitted). Approximately 4% of the younger youths and 7% of the older youths reported having been involved. Males were again more likely to have participated than females. Among the younger youths, 6% of males versus 2% of females and among the older youths, 11% of males versus 4% of females had been involved in drug-trafficking. While intent was not assessed among these youths, they were questioned as to whether they had ever been asked to sell or deliver drugs; 7% reported having been asked.

Data are not available at a national or state level regarding involvement in drug-trafficking. However, one recent statewide survey conducted among 18,348 students attending Maryland middle and upper schools did ascertain how many youths had ever been approached to sell drugs (MD Department of Education, 1992). In this survey increasing age and substance abuse were positively correlated with having been asked to sell drugs. For example, 40% of tenth-grade youths who had used drugs other than alcohol and cigarettes reported having been approached to sell drugs. However, rates among youths who did not use substances were also high; 5% of abstaining sixth graders and 15% of abstaining 10th graders had been asked to sell drugs. African-Americans were twice as likely as whites to be approached, even though their substance-use rates were lower.

The fifth survey included 387 minority males recruited from both recreation centers and ninth and tenth grades from schools in Washington, D.C. (Brounstein 1990). In this study 13% of the youths had sold drugs. This figure was consistent with that reported for

males in the Baltimore surveys and among the 7/8th grade males in the Washington, D.C. study.

It is useful to place these prevalence rates in perspective by comparing them with rates of other substance-abuse related behaviors among urban adolescent youths. In the 1992 Baltimore study (Li, submitteda), in which 9% of youths reported selling and/or delivering drugs, 11% of the youths reported use of tobacco, 7% of alcohol, 2% of marijuana, and 1% of other illegal drugs in the past 6 months. These reported rates of substance abuse are comparable to those found by other state (Md Dept Ed, 1992) and national (Johnson 1992) surveys.

In summary, among urban African-American pre- and early adolescents, approximately one-tenth of males and one-twentieth of females report having engaged in drug-trafficking. Rates are higher among youths approaching mid-adolescence. Further, even more youths report having been asked to sell drugs and indicate that they expect to become involved in drug-trafficking. Reported rates of drug-trafficking are comparable to rates of tobacco and alcohol use among early adolescents and are substantially higher than use-rates of illegal drugs.

Factors associated with drug-trafficking

Drug-trafficking is both prevalent and associated with significant adverse health outcomes among urban adolescent youths. Drug-trafficking thus constitutes an important public health problem, demanding further understanding to prepare potential intervention options.

Data from the 1993 Baltimore community survey (Li, submittedb) and the Washington D.C. school-based survey (Bush, submitted) describe environmental and individual factors associated with adolescent drug-trafficking to generate hypotheses for future causal and intervention research.

Potentially relevant factors may be classified into external factors (neighborhood exposure, perceived involvement of friends and family members) and internal factors (personality attributes, perceptions of the severity of the consequences of drug-selling and perceptions of the costs of not selling.)

External Factors

Community Factors: In the Washington study youths who had sold drugs or had been asked to sell drugs were more likely to perceive their neighbors as involved in drug-trafficking. In the Baltimore study, the majority of youths perceived that their neighbors were involved in drug-trafficking; this perception that did not vary by actual or intended drug-trafficking experience.

Family involvement: Youths who perceived that family members were involved in drug-trafficking or drug-use were significantly more likely to have engaged in drug-trafficking themselves in both

studies. As well, in the Baltimore study, this perception was also significantly elevated among youths who thought it likely that they would be involved in drug-trafficking in the future.

Peer Involvement: In the Baltimore study, the perception that friends are involved in drug-trafficking was highly correlated with both actual involvement in drug-trafficking and intention. Likewise, the perceptions that people who sell drugs are "cool" and/or fun to be around were also associated with both actual and intended drug-trafficking. The perception that friends will respect a youth who is arrested was strongly correlated with involvement in drug-trafficking.

Internal factors

Other behaviors: Involvement in other delinquent behaviors including school truancy, weapon-carrying, fighting, and high-risk sexual behavior (e.g. anal intercourse) were strongly correlated with actual and intended drug-trafficking in the Baltimore study. In both studies youths who had been or intended to be involved in drug-trafficking and youths who had been approached to sell drugs were more likely than other youths to have used cigarettes, alcohol, and illegal drugs.

Perceptions of vulnerability and severity: These factors were only assessed in the Baltimore study. Youths who had engaged in drug-trafficking or expected to become involved were substantially more likely to believe that they would be arrested sometime in the future than uninvolved youths. The youths who had engaged were also more likely to believe that they would be arrested regardless of any involvement in drug-related activities than youths who had not engaged in drug-trafficking. Youths expecting to traffick drugs were less likely to think that adolescent drug-traffickers could get hurt from the activity or that imprisonment would "ruin" a youth's life. They also were more likely to believe that a youth would be able to stop drug-trafficking whenever (s)he desired.

Perceptions of the need to sell drugs: Finally, in the Baltimore study, youths who had engaged in or intended to engage in drug-trafficking endorsed the importance of drug-trafficking as the sole means by which youths could make money. They were also significantly more likely to believe that they needed money to buy articles both for themselves, to help support their family, or to pay for gifts for a girl- or boyfriend.

Discussion

There is strong evidence that drug-trafficking is a major cause of urban homicide in recent years. Further, a substantial percent of early adolescents (especially minority males residing in low-income urban areas) are participating in this behavior. Youths who engage in drug-trafficking are more likely to believe that other family members and their peers are engaging in this practice, that drug-trafficking will not change their (already high) chances

of incarceration, and that this activity is the only way for them to earn money for their perceived social-economic obligations.

This analysis has focussed primarily on drug-trafficking among minority youths living in economically depressed urban areas. However, this focus does not imply that minority youths are the only participants in adolescent drug-trafficking or that the practice is confined to inner-city areas. To the contrary, although national or regional demographic data is not available to permit comparisons based on race, anecdotal evidence in recent years clearly indicates that white youths and youths living in more affluent suburban areas are also involved in drug-trafficking (Mydans 1990; Myers 1993). However, in this paper we have focussed on the involvement of minority youths because of the substantial evidence that the major adverse consequences of drug-trafficking are encumbered by minority youths. Further, a growing research experience indicates that the antecedents of behaviors and practices may differ between sub-cultures, such as those associated with racial and/or socio-economic differences. In order to design interventions regarding drug-trafficking which are effective for minority, urban adolescents, the prevalence and role of this practice must be examined within this social and geographic context (Mays 1991; Dembo 1985).

Implications of the findings

The data presented in this study, indicating that drug-trafficking may account for over one-third of all homicides, have far-reaching implications, especially for African-American adolescents, if validated in this age-group. Thus, for example, of the 13,043 deaths due to homicide among adolescents and young adults in 1988 (CDC 1992), up to 6,000 may have resulted from drug-trafficking. Homicides are currently the leading cause of death for African-Americans between the ages of 15 and 34, the second most common cause of death for all individuals in this age range, and the third most common cause of death for all youths aged 10 to 14. (CDC 1992)

Second, while the factors related to drug-trafficking do have some overlap with those related to drug-use, they are not identical. Perceptions of family, peer and environmental involvement are also associated with increased involvement in substance abuse (Dembo 1985; Jessor 1977). Likewise, high rates of participation in other risk-behaviors have also been reported among substance-abusing youths (Donovan 1988; Millstein 1992). However, there are additional factors that have not been reported as associated with substance abuse alone, including the perceived inevitability of incarceration (and its anticipated lack of impact on a youth's life) and the economic drive for involvement in the risk activity. Ethnographic studies have indicated that some urban youths may simultaneously regard drug-use as negative while holding ambivalent or even positive views regarding drug-trafficking. In fact, some youths believe that drug-trafficking may protect youths against involvement in drug-use (Feigelman 1993). While expenditures targeting substance-abuse efforts have been

substantial and numerous programs for youths exist, intervention efforts regarding adolescent drug-trafficking are virtually nonexistent. For example, a recent call to three national substance-abuse clearing houses revealed no educational materials regarding drug-trafficking. Greater understanding of the antecedents of drug-trafficking will be needed for future interventions efforts, but the data presented in this paper suggests that drug-trafficking interventions will require some different emphases and strategies than drug-use interventions (Altschuler 1991).

Need for additional background knowledge

Additional information is needed regarding the prevalence of drug-trafficking at a national level, including the racial, geographic, and age-distribution of the practice. The arrest figures by race would indicate that this behavior is virtually confined to African-Americans. However, there are several reasons to challenge this presumptive association. First, there are no nationally or regionally representative surveys comparing rates of drug-trafficking by race. It is of interest that in most national surveys, drug-use rates among African-American youths are lower than those among white youths. Given the strong association between drug-use and drug-trafficking, this national pattern would seem to mitigate against higher rates of drug-trafficking among African-American youths. Second, arrest rates reflect not only the criminal practice, but also the organizational characteristics of the control agencies, and the interaction between the social control agencies, the public, and the arrestees (Harris 1988). Particularly for crimes such as drug-trafficking in which there is considerable latitude regarding the criminal charge levied (NCIA 1992), arrest rates may not be reflective of actual prevalence rates. Therefore, both to assess the over-all magnitude of the problem and to begin to understand potential racial inequities in the current application of laws, it will be important for nationally representative surveys such as the National Household Survey and the Monitoring the Future Survey to include questions regarding drug-trafficking.

Intervention directions

Violence among adolescents is a complex problem with multiple antecedents. Evidence for the association of urban violence and drug-trafficking is compelling and argues for anti-violence efforts to include a strong focus on drug-trafficking. Both the causes and consequences of this practice have economic, legal, psychologic and environmental components. Therefore, intervention efforts will require multi-system, integrated approaches that are culturally and developmentally appropriate for these youths (Dryfoos 1990). Altering the perception that drug-trafficking is normative within the micro-society will be important to intervention efforts (Dembo 1985; Feigelman 1992). Altering these perceptions will require coordinated community efforts involving not only schools and health services, but also the mass media. There is good evidence to support a potentially significant role for the mass media in

altering and/or reinforcing perceptions regarding the prevalence of violence and the desirability of non-threatening alternatives to violence (Romer 1993), although clearly experimentation will be required to achieve the most effective means of reaching minority, disenfranchised youths (MEE 1992). In addition, given the importance of the church among the majority of minority youths and their families (Romer 1993), this channel should also be used to "normalize" non-violent, anti-drug-trafficking attitudes. Changes in the legal system will be necessary both to counter perceptions of the inevitability of arrest and the perception that being arrested is not a negative outcome. Likewise, re-examination of handgun restrictions will be essential. Interpersonal negotiation strategies to aid youths in their attempts to resist pressure to become involved in drug-trafficking will be necessary. Finally, the short-term and long-term economic realities and perceptions for these youths and their families must be altered. Innovation programs offering rehabilitative training to first-time offenders should be given especial attention.

Outcomes research: Evaluating intervention impact

Violence, including that resulting from drug-trafficking, results in substantial human suffering and cost to society. Death, permanent and/or prolonged disability, and depression are but three of the many negative health outcome resulting from violent behavior. While demonstration programs and "good ideas" abound, rigorous evaluation of the actual health impact of these prevention and treatment efforts will be essential. Interventions which are primarily behavioral require as rigorous evaluation of impact as interventions which are bio-technical. Outcomes to be assessed should include homicide rates but also might include other measures of violent-behavior such as emergency room visits of trauma-related injury, school-reports of violence, and self-reported involvement in drug-trafficking and/or violent behavior. The analytic framework offered in the New York analysis of cause of homicide (Goldstein 1990) provides a useful model for tracking intervention impact on specific causes of homicide. Evaluation approaches should include specific, "case-studies" as well as larger, population-based evaluations using existing and/or ongoing national data-collection systems, such as the national drug-surveys, as noted earlier. Assessments which incorporate both desired outcomes and "costs" required to achieve these outcomes will be important to allow for appropriate allocation of resources.

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Mr. TOWNS. Thank you very much, Dr. Stanton.
Dr. Kellermann.

**STATEMENT OF ARTHUR L. KELLERMANN, M.D., ASSOCIATE
PROFESSOR OF EMERGENCY MEDICINE AND PUBLIC
HEALTH, EMORY UNIVERSITY SCHOOL OF MEDICINE**

Dr. KELLERMANN. Mr. Chairman, my name is Arthur Kellermann and I am an emergency physician. My colleagues and I serve on the front lines of America's health care system. As providers of emergency and trauma care, we see the consequences of violence 24 hours a day, 7 days a week.

My desire to work harder to prevent the consequences of violence led me to resign my position as director of the Emergency Department at the Regional Medical Center in Memphis in order to move to Atlanta to direct the Center for Injury Control at Emory University. Although I continue to practice emergency medicine, my colleagues at the American College of Emergency Physicians and I are determined to do more than simply react to violence and its consequences.

Injuries, particularly injuries due to violence, have long been considered an inevitable consequence of living in a modern society. We now know that injuries disproportionately affect high-risk groups, follow an often predictable change of events, and are therefore preventable.

The dramatic gains we made in the prevention of motor-vehicle-related trauma is a case in point. For decades the Federal Government spent untold millions of dollars trying to fix the nut behind the wheel. It was not until we shifted our focus to building safer cars and better highways that our horrendous death rate due to car crashes began to fall. As a result of these efforts, the rate of deaths and disability per vehicle mile traveled today is less than half what it once was.

Now, guns are second only to motor vehicles as a cause of fatal injury in the United States. Ironically, as we succeed in our efforts to control many motor vehicle related deaths and ignore gun-related violence, there are signs that this relationship may change. In at least two States, Texas and Louisiana, firearms have already overtaken motor vehicles as the leading cause of fatal injury. The rest of the Nation is not far behind.

Firearm-related fatalities are usually buried in State and national statistics on suicide, homicide, and unintentional deaths. When they are grouped together, guns emerge as the leading cause of death in the United States and the second leading cause of death among Americans age 15 to 34.

During the 1980's, guns killed 3 times as many Americans as the AIDS virus and more than 5 times the number of Americans that died during the entire history of our military involvement in Vietnam.

You have heard from previous witnesses estimates that guns in this country cost society \$16 to \$20 billion a year in medical care costs, disability, and premature death. We may not be sure exactly how much guns cost society, but we have got a pretty good idea who is picking up the bill. Private insurance and other sources of

reimbursement pay less than 15 percent of the costs of medical care. The rest is covered by public funds or written off.

As a result, violence is having a major impact on our Nation's trauma and emergency care system. The high cost of treating victims of violence has forced scores of trauma centers to close. In cities like Atlanta, Miami, and Los Angeles, public hospitals are all that stand between the community and a complete collapse in trauma care.

Violence is also eroding the social fabric that binds our society together. The shooting of three emergency physicians in a Los Angeles hospital earlier this year shattered the illusion that many health care workers held that we were immune.

Emergency departments were once considered a haven from the dangers of the street. Now we know that violence can be transported as easily as a small caliber handgun. It can strike in homes, our schools, our courthouses, and even our hospitals.

Although these statistics are disturbing, they cannot convey the devastating emotional impact of gun-related death. When an innocent child is cut down in cross-fire, a teenager ends his life with his father's gun or a man is shot in a trivial dispute, their lives, and the lives of everyone in their family and neighborhood, are changed forever.

The police are doing everything they can, but they can't do it alone. Many deaths and injuries due to violence can be prevented. There are reasons to believe, however, that progress will be difficult to achieve.

First, the resources presently committed to violence research are inadequate to meet the task. The National Research Council recently reported that the Federal Government spent less than \$20 million on violence research in 1989. This investment—on average of \$3.41 per violent incident—pales in comparison to the cost of violent crime: \$54,000 per rape, \$19,200 per robbery, and \$16,500 per aggravated assault.

Second, we presently lack the capacity to monitor violence as a public health problem. Development of a firearm fatality reporting system and minor modifications to the national crime survey, the national health interview survey, and the national electronic injury surveillance system could dramatically enhance our ability to document the magnitude and extent of firearm violence and assess the effectiveness of violence prevention programs. The support of these measures must come from you and your fellow Members of Congress.

Third, we must resist the temptation to single out a particular group—such as teenagers—or a particular strategy as our sole response to violence. Line item programs are a poor substitute for a broad-based research program that seeks to understand all the individual family and societal forces that influence violence.

Many factors promote violent behavior or worsen its consequences. We need a clearer understanding of the role of poverty, illegal drugs, racism, unemployment, child abuse, the media, and the marketing of guns.

Rather than be overwhelmed by the weight of these problems, we should view each of them as an opportunity to make a difference. We must be open to any idea, any strategy that might work. It will

be equally important, however, to subject each of these promising ideas to rigorous examination. It is not enough for each of us to run out and do something about violence. We must invest the time and sufficient resources to determine if our efforts are doing any good.

Now, the challenges are great, but there is cause for hope. We can all remember when the automobile industry fought efforts to improve the safety of motor vehicles because it would cost too much. Now safety sells, and the Nation saves billions each year from crash-related deaths and injuries that didn't happen.

The gun begun industry is not likely to be any more receptive to a broadening of our focus from the hand behind the gun to the gun itself, but this change is also overdue. Modifications to the design of firearms to make them less destructive and much less prone to unintentional discharge or criminal misuse can be done, and should be done now.

A generation ago, Hollywood glamorized cigarettes, and more than half of all Americans smoked. After research demonstrated a link between cigarette smoke and an increased risk of heart disease, emphysema, and lung cancer, public attitudes about smoking began to change. Today, far fewer people choose to smoke, and our rate of cigarette-related heart disease has substantially declined.

Perhaps, a generation hence, our children may look back to a time when Hollywood glamorized gun violence and half of all homes in America contained one or more firearms.

Research has recently demonstrated a strong link between gun ownership and an increased risk of homicide, suicide, and unintentional gunshot deaths, and public attitudes about handguns are beginning to change. Perhaps some day, far fewer people will choose to own guns, and our death rate due to firearms will substantially decline.

In closing, I want to remind you that although violence is an enormous public health problem, it is only one piece of the \$180 billion pie that represents the cost of injury in the United States. The Clinton administration's proposal for health care reform has identified disease prevention and primary care as cornerstones of its program to control costs.

I would argue that a comparable investment in injury prevention and emergency care could save billions of dollars and tens of thousands of lives each year.

Thank you for your attention.

[The prepared statement of Dr. Kellermann follows:]

**The Bullet as Pathogen:
Preventing Deaths and Injuries Due to Firearm Violence**

Arthur L. Kellermann, M.D., M.P.H.

from the Center for Injury Control, School of Public Health, and the Division of Emergency Medicine, Department of Surgery, School of Medicine, Emory University, Atlanta, Georgia.

Dr. Arthur Kellermann is Director of the Center for Injury Control, Emory University School of Public Health, and an Associate Professor of Emergency Medicine in the department of Surgery at the Emory University School of Medicine. After obtaining his M.D. degree from Emory University, Dr. Kellermann moved to Seattle where he completed his residency training in Internal Medicine and earned an M.P.H. degree from the University of Washington School of Public Health. Dr. Kellermann initiated his first study of the epidemiology of firearm injuries with support from the Robert Wood Johnson Clinical Scholars Program in 1983.

In 1985, Dr. Kellermann accepted an appointment as Chief of the Division of Emergency Medicine at the University of Tennessee, Memphis. He also served as Medical Director of the Emergency Department of the Regional Medical Center at Memphis. Between 1991 and 1993, he represented the fields of Medicine and Public Health on the National Research Council Panel on the Understanding and Control of Violent Behavior. In September of this year, he moved to Atlanta to establish the Emory Center for Injury Control.

Dr. Kellermann and colleagues at the Harborview Injury Prevention and Research Center in Seattle and Case Western Reserve University in Cleveland recently completed a CDC sponsored study of homicide in the home in relation to gun ownership. They found a strong association between homicide and the immediate availability of a gun, even after other major risk factors were taken into consideration. Keeping a gun in the home was not found to be protective from homicide, even in the small percentage of cases that followed forced entry into the home. The study was published in the October 7, 1993 issue of the *New England Journal of Medicine*.

Introduction

Injuries (particularly injuries due to violence) have long been considered an inevitable consequence of living in a modern society. We now know that injuries disproportionately affect high risk groups, follow an often predictable chain of events and are therefore *preventable*.

The dramatic gains we have made in the prevention of motor vehicle related trauma is a case in point. For decades, the federal government spent untold millions of dollars trying to fix "the nut behind the wheel." It was not until we shifted our focus to building safer cars and better highways that our horrendous death rate due to car crashes began to fall. As a result of these efforts, the toll of death and disability per vehicle mile traveled today is less than half what it once was.

Guns are second only to motor vehicles as a cause of fatal injury in the United States. Ironically, as we succeed in our efforts to prevent many motor vehicle related deaths and ignore gun related violence, there are signs that this relationship may change. In at least two states (Texas and Louisiana) firearms have already overtaken motor vehicles as the leading cause of fatal injury. The rest of the nation is not far behind.

Firearm violence: deaths, injuries and costs

Firearm related fatalities are usually buried in state and national statistics on suicide, homicide and unintentional deaths. When they are grouped together, guns emerge as the eighth leading cause of death in the United States and the second leading cause of death among Americans aged 15-34. (fig. 1) During the decade of the 80's, guns killed more than three times as many Americans as the AIDS virus, and more than 5 times the number of Americans who died during the entire history of our military involvement in Vietnam. (fig. 2)

Consider the following facts: each year, approximately 33,000 Americans die from gunshot wounds. Guns kill more U.S. teenagers than all "natural" causes of death combined. Fatalities are only the tip of the iceberg. It is estimated that the annual toll of gun related injuries is four to seven times larger than the number of firearm related fatalities. (fig. 3) The costs associated with emergency department care, trauma surgery, hospitalization, rehabilitation and lost income due to premature death and disability are staggering. A 1989 report to Congress estimated that the lifetime cost of firearm injuries in 1985 alone exceeded 14 billion dollars. The cost today is probably closer to 16 to 20 billion dollars per year.

We may not be sure how much gun violence costs, but we have a pretty good idea who's paying the bill. Private insurance and other sources of reimbursement pick up less than 15 percent of the tab. The rest must be covered by public funds or written off. (fig. 4)

Violence has had a devastating impact on our nation's trauma and emergency care system. The high cost of treating victims of violence has forced scores of trauma centers to close. In cities like Atlanta, Miami, and Los Angeles, public hospitals are all that stand between the community and a complete collapse of trauma care.

Violence is also eroding the social fabric that binds our society together. The shooting of three emergency physicians in a Los Angeles hospital earlier this year shattered the illusion many health care workers held that we were immune. Emergency departments were once considered a haven from the dangers of the street. Now we know that violence can be transported as easily as a small caliber handgun. It can strike in our homes, our schools, our courthouses and even our hospitals.

Although these statistics are disturbing, they cannot convey the devastating emotional impact of gun related death. When an innocent child is cut down in cross-fire, a teenager ends his life with his fathers gun or a young man is shot in a trivial dispute, their lives, and the lives of everyone in their family and neighborhood, are changed forever.

Barriers to Progress

The police are doing everything they can, but they can't do it alone. Many deaths and injuries due to violence can be prevented. There are reasons to believe, however, that progress will be difficult to achieve.

First, the resources presently committed to violence research are totally inadequate to meet the task. The National Research council recently reported that the federal government spent only 20 million dollars on violence research in 1989. This investment (an average of \$3.41 per violent incident pales in comparison to the cost of these events: \$54,000 per rape, \$19,200 per robbery, and \$16,500 per aggravated assault.

Second, we presently lack the capacity to monitor violence as a public health problem. Development of firearm fatality reporting system and minor modifications to the National Crime Survey, the National Health Interview Survey and the National Electronic Injury Surveillance System could dramatically enhance our ability to document the magnitude and extent of firearm violence and assess the effectiveness of violence prevention programs. The support for these measures must come from you and your fellow members of Congress.

Third, we must resist the temptation to single out a particular group, problem or strategy as our sole response to violence. Line item appropriations or categorical programs are a poor substitute for a broad based research program that seeks to understand all of the individual, family, and societal forces which influence violence. Many factors promote violent behavior or worsen its consequences. We need to more clearly understand the role of poverty, illegal drugs, racism, unemployment, child abuse, the media, and the marketing of guns. Rather than be overwhelmed by the weight of these problems, we should view each of them as an opportunity to make a difference. We must be open to any idea- any strategy- that might work.

It will be equally important, however, to subject each promising idea to rigorous evaluation. It's not enough to run out and "do something" about violence. We must invest the time, and sufficient resources, to determine if our efforts are doing any good.

Hope for the Future

The challenges are great, but we have cause for hope. We can all remember when the automobile industry fought efforts to improve the safety of motor vehicles because it would "cost too much." Now safety sells, and the nation saves billions each year from crash related deaths and injuries that didn't happen. The gun industry is not likely to be any more receptive to a broadening of our focus from the "hand behind the gun" to the gun itself, but this change is overdue. Modifications to the design of firearms could make them less destructive and much less prone to unintentional discharge or criminal misuse than they are today.

A generation ago, Hollywood glamorized cigarettes, and more than half of all Americans smoked. After research demonstrated a strong link between cigarette smoking and an increased risk of heart disease, emphysema and lung cancer, public attitudes about smoking began to change. Today, far fewer people choose to smoke, and our rate of cigarette-related heart disease has substantially declined.

A generation hence, our children may look back at a time when Hollywood glamorized gun violence and half of all homes in America contained one or more firearms. Research has recently demonstrated a strong link between gun ownership and an increased risk of homicide, suicide and unintentional gunshot deaths, and public attitudes about handguns are beginning to change. Perhaps someday, far fewer people will choose to own guns, and our death rate due to firearms will substantially decline.

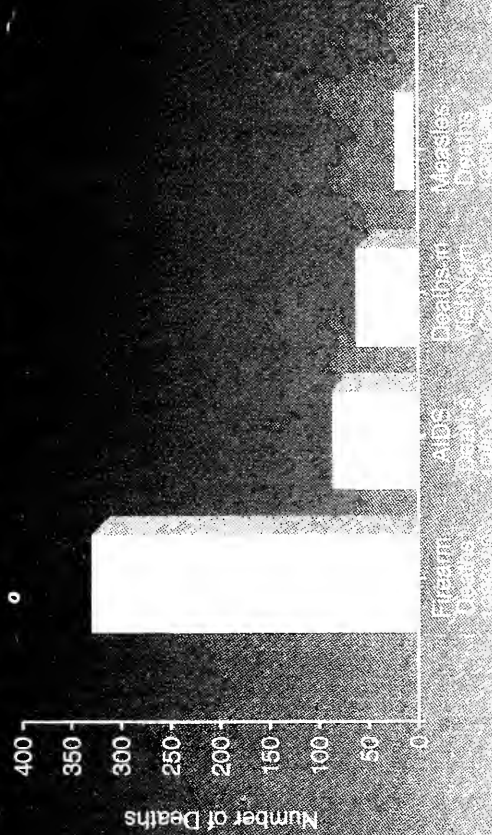
In closing, I want to remind you that although violence is an enormous public health problem, it is only one piece of the 180 billion dollar pie that represents the cost of injury in the United States. (fig. 5) The Clinton Administration's proposal for health care reform has identified disease prevention and primary care as cornerstones of its program to control costs. A comparable investment in *injury* prevention and *emergency* care could save billions of dollars and tens of thousands of lives each year.

Ten Leading Causes of Death by Age Group - 1988

Age Groups										
Rank	0-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65+	Total
1	Prenatal Period 18,165	Unintentional Injuries 2,102	Unintentional Injuries 2,113	Unintentional Injuries 3,507	Unintentional Injuries 16,728	Malignant Neoplasms 15,581	Malignant Neoplasms 38,766	Malignant Neoplasms 97,656	Heart Disease 627,494	Heart Disease 765,156
2	Congenital Anomalies 9,054	Malignant Neoplasms 588				Heart Disease 12,070	Heart Disease 31,758	Heart Disease 87,514	Malignant Neoplasms 324,187	Malignant Neoplasms 485,048
3	Unintentional Injuries 3,794	Congenital Anomalies 281	Malignant Neoplasms 510	Non-Firearm Suicide 1,914	HIV 6,036	Unintentional Injuries 1,551	Unintentional Injuries 7,514	Cerebro- vascular 11,196	Cerebro- vascular 130,745	Cerebro- vascular 150,517
4	Heart Disease 1,223	Heart Disease 146	Congenital Anomalies 218	Malignant Neoplasms 1,894	Malignant Neoplasms 5,211	HIV 6,184	Liver Disease 4,780	Bronchitis Emphysema Asthma 10,659	Bronchitis Emphysema Asthma 68,614	Unintentional Injuries 97,100
5	Pneumonia & Influenza 827		Heart Disease 178		Heart Disease 3,575		Cerebro- vascular 4,630	Unintentional Injuries 7,663	Pneumonia & Influenza 68,343	Bronchitis Emphysema Asthma 92,853
6			Non-Firearm Suicide 112	Heart Disease 1,090	Non-Firearm Suicide 3,004	Liver Disease 3,563		Liver Disease 6,990	Diabetes 29,547	Pneumonia & Influenza 77,662
7	Malignant Neoplasms 631	Pneumonia & Influenza 66		HIV 535		Cerebro- vascular 2,423	Diabetes 2,592	Diabetes 6,109	Unintentional Injuries 26,936	Diabetes 40,368
8	Septicemia 334	Benign Neoplasms 54	Bronchitis Emphysema Asthma 71	Congenital Anomalies 474	Liver Disease 1,057	Non-Firearm Suicide 2,337	HIV 2,352	Pneumonia & Influenza 4,124	Alcohol- related 2,105	Heart Disease 30,359
9	Meningitis 334	HIV 37	Pneumonia & Influenza 61	Cerebro- vascular 266	Cerebro- vascular 969	Diabetes 1,395	Bronchitis Emphysema Asthma 2,259		Nephritis 18,453	Liver Disease 26,409
10	Nephritis 239	Cerebro- vascular 32	Benign Neoplasms 49	Pneumonia & Influenza 266	Pneumonia & Influenza 845		Pneumonia & Influenza 1,771	Nephritis 2,058	Septicemia 16,876	Nephritis 22,392

(Revised - September 1993)

Firearm Fatalities During the 1980's Compared with Selected Causes of Death, United States



CDC

Firearm Injury Pyramid, United States, 1988

33,989 Firearm-related deaths

? Firearm-related disabilities

Estimated 184,186
nonhospitalized
firearm-related
injuries

CDC

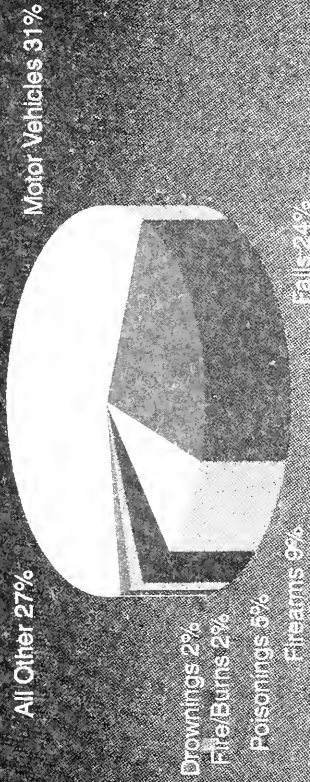
Source of Payment for Hospital Costs of Firearm-Related Injuries San Francisco General Hospital, 1984



CDC

Wassenaar, Hunt TK, Holley SE. The Cost of Hospitalization
for Firearm Injuries. JAMA 260(20):3048-3050.

Total Lifetime Cost of Injury for 1985 is \$158 Billion



For 1986, the total lifetime cost of injury is estimated at \$160 billion.

CDC

Mr. TOWNS. Let me thank both of you for your testimony.

Let me open by saying hopefully we will have an opportunity to pass the Brady bill before we recess this year. What other actions should we take as Members of Congress to try to reduce the incidence of violence?

Dr. KELLERMANN. Injury control experts usually outline three main strategies for dealing with an injury problem. We call it the three Es: education, enforcement, and engineering.

We have heard a great deal today about education, as we should. We need to educate health care providers to intervene with victims of violence at an early point in the cycle of victimization, but we also need to educate people about the benefits and risks associated with owning guns.

In this room, we are in a gun-free zone. People argue in this society that guns are not part of the problem, they are part of the solution. I am not sure very many people in this country would feel safer if they had a gun in their pocket and knew that half the people in this room were carrying a firearm. I think we feel safe because we went through metal detectors to get here that there are no guns in this room.

Yet, many expect people in society to feel comfortable with a gun in their pocket and half of our homes containing firearms. This is false security. We need to educate the public through science, the media, and our words and actions that having a gun provides false security. The kids who testified today, the family members who testified today, are compelling evidence that the security of gun ownership is largely an illusion.

Second, we clearly need to do a better job enforcing the laws that are clearly on the books, particularly those that are intended to keep guns from getting into the hands of kids.

Think of the young people who testified on the panel before this one. Not one of them owns a gun factory. Not one of them is a federally licensed gun dealer. Not one of them owns a major movie or television studio. They are not the perpetrators of the problems that we are dealing with in society. They are its victims.

We need to more broaden the net of accountability so that manufacturers, licensed gun dealers, and purchasers need to pay a higher share of taxes and stiffer licensing fees to bear a fair share of the cost of gun violence to society.

The Brady bill is a terribly important start, but I don't think it will be enough. I think we have to ban assault weapons. I think we have to take a tough look at handguns. And I think we have to be willing to look at effective, strategic use of taxation and other strategies to decrease demand for weapons and generate needed money to offset the costs of gun violence.

Finally, I don't think we should overlook the value of engineering. They are marketing handguns like the Lady Smith to women as something they need for self-protection. Many of the handguns being sold to women don't even include a safety to make that gun child-proof. I think that is outrageous.

I think any manufacturer that makes a firearm that is not purposefully engineered so it is difficult or impossible to be fired by a small child should be held accountable for that design oversight. If we can put a man on the moon, we can sure as hell invent a single-

user specific gun or a gun that can't be easily discharged by a small child or someone who grabs it in a moment of anger. We are smart. We are the best engineers in the world. However, if we can't figure out how to make a safer gun, we are pretty pitiful.

We should leave no stone unturned, no option untried. When we do adopt countermeasures, we must evaluate them for effectiveness. We must do whatever it takes to make a difference in this enormous problem.

Mr. TOWNS. Thank you very much, Dr. Kellermann.

Dr. Stanton, there has been a lot of discussion about mandating medical schools to include some instruction about how to deal with victims of domestic violence in the curriculum. Do you think this kind of instruction should be expanded to cover violence generally?

Dr. STANTON. I think that is an excellent question and I think it is long overdue. I think that the increased focus in recent years on domestic violence, particularly child abuse, by the broader issue of domestic violence, has brought about substantial change in clinical practice. It has been documented in quite a few studies of medical students and physicians that we all recognize that much of the increase that we are seeing in child abuse probably reflects an increased sensitization of doctors, who now are aware that the problem is there, and that there are treatment options for these children, and it is probably due to curricular changes that made them comfortable and therefore able/willing to actually "detect" the abuse.

We have seen some changes in adult-adult domestic violence. But, because there have been so few programs yet addressing the issue of nondomestic violence in the medical school curriculum, we haven't seen corresponding changes in this area yet. So, in summary I think a suggestion to expand the medical school curriculum to cover violence is excellent.

Mr. TOWNS. Thank you very much.

Let me ask I guess both of you this particular question. What can we do in the health care reform to support violence preventive activities?

We are moving here again with this whole health care reform package, and I don't think there is enough emphasis, being put on the prevention of violence. What can we do to maybe create the kind of protection that needs to be there?

Dr. STANTON. I think one of the most exciting things about the health care reform is its emphasis on primary health care and prevention. And as Dr. Kellermann and really everyone this morning has alluded to, if there is one area of health need that is going to be responsive to a primary health care and prevention approach it is violence.

I think that orienting physicians toward the community will be essential. And likewise, just as medical students and the doctors have to move out into the community and into many of the prevention programs that are community based, I think that these same community-based programs must learn to invite the participation of physicians, in effect, to "insist" that we be there.

For example in Baltimore, partnerships are developing between the medical school and public housing developments, and between the medical school and the local schools. These examples of pri-

mary health care with a focus on violence prevention will be essential, I think, to the health care reform. This is what primary health care should be.

Second, I think we need to look to some of the activities that are resulting in the increase of violence. I think there is little question that the actual deaths that are occurring as a result of violence are attached to the increase in the number of guns. But we are also seeing a huge increase in violence in general that isn't necessarily resulting in deaths. Much of this increase in violence appears to be related to drug trafficking.

We first became concerned about drug trafficking as we began to conduct ethnographic studies with community members, and they increasingly were pointing toward drug trafficking. When we began to do epidemiologic analysis of violence—particularly of homicides, but also nonhomicidal traumas—we realized that much of the serious violence is occurring in the context of drug trafficking. Moreover, for a variety of legal reasons, drug trafficking is increasingly involving younger and younger children. It is not at all uncommon, as we all know, for children aged 8, 9, 10, 11 years to be involved.

So at the same time we have a broad-based approach—primary health care moving into the community—and that we have specific content approach—the gun control legislation—I think we also have to start looking at some of the big areas of behavior that are contributing to the worst tolls of violence.

Dr. KELLERMANN. I think in very practical terms we don't have to reinvent the wheel. We have to do a better job at maintaining the wheels we've got to roll down the road.

The National Center for Injury Prevention and Control receives a pitiful amount of funding to control violence, particularly when you consider that injuries are the leading health care cost for Americans between the age of 5 and 50. They have developed mechanisms for funding, evaluating pilot programs, and building the capacity of local and State health departments to make a big difference.

The National Institute of Justice also has a superb program to look not only at standard criminal approaches but preventive approaches as well. Congress needs to take a leadership role and put more dollars into these prevention-oriented programs. Congress should also demand that these programs allocate resources to evaluate the impact of these efforts.

We must be careful though. This is such a pressing problem right now that we are about to run out and throw programs on the street without really knowing if they are making an impact. Program evaluation is going to be terribly important.

If Congress will get in front on this issue, we can make a difference. This isn't just a matter of doing good and making people feel good. This is smart money. Because every dollar we spend today to limit the consequences of violence will be paid back later with interest through decreased health bills, decreased societal costs, and a more productive, healthier work force in coming generations.

Mr. TOWNS. Thank you.

Let me raise one other question with you. You sort of alluded to it. What specific changes would you recommend in our data reporting system? What would you recommend that we do there?

Mr. KELLERMANN. A couple of things. Recently an article appeared in the Journal of the American Medical Association that advocated the development of a firearm fatality reporting system. Currently we have a system for fatal car crashes called the fatal accident reporting system that really has led to a lot of the landmark work in motor vehicle safety.

A comparable surveillance system could be created for every gun fatality in this country that would yield us a very rich data base on the incident, the circumstances, the individuals involved, what kind of gun was involved, and where it came from. That could be done for about \$2.5 million a year, about what Congress authorized this year for the civilian marksmanship program and supported again last week.

For the same amount of money, we could fund this system.

The three surveys that I described are already funded. They already exist. All we have to do is tinker with the questions. That could be done for virtually nothing. The national health interview survey, for example, asks a large sample of Americans every year when were they sick, when were they hurt, how did they use health care, how they are functioning. It gives us a snapshot of the health of the American public.

Not one gun-related question has been included on any edition of the national health interview survey since 1972. Was that an oversight or was that a conscious decision? I don't know, but it could be changed at virtually no cost at all just by rewriting next year's questionnaire.

So we could gain a wealth of information at very little cost, and then we will know where to go. It is hard to drive down a road when the windshield is painted over. We need information to be able to make sound public policy decisions.

Dr. STANTON. In addition to that, I would like to point out that although there are now many national drug surveys, some of which are targeting the adult population and many which are targeting adolescents, on these national questionnaires, there are no questions about drug trafficking. We now know that the prevalence of drug trafficking is probably greater, and certainly in the areas where there have been spot studies, than substance abuse in early adolescence.

We also are beginning to get data to suggest that the consequences in terms of violence and homicide are far greater. And the flip side of that is there have been some very nice work done in New York to suggest that if we looked at the actual causes of homicide, if we made that part of standard reporting, we again would begin to get a very different picture of what the background to the homicides are.

In fact, we have very little data that is built into the standard data collecting systems that lets us get into this fundamental question.

Mr. TOWNS. Thank you very much.

Let me raise this and just say in advance, I realize you are not a psychiatrist. I realize you are not a lawyer and I realize you are

not a judge, but your background is so extensive I feel very comfortable raising this with you and I would like to hear you on this point.

Will it help to reduce gun violence if we make it a Federal offense for anyone under the age of 18 to possess a handgun, or will it provide just another means to bring minority youth into the criminal justice system? I would like to get both of your responses on that issue.

Mr. KELLERMANN. I suspect the latter would be far more the case than the former. Again, a fundamental principal of public health is to go after a problem at the point source. For us to try somehow, through passage of a law, to interdict or interrupt the flow of guns into the hands of teenagers on the street level is unlikely to work. We are kidding ourselves. All we are going to do is put more kids in jail and keep more kids out of college.

What we have to do is shift our focus back to the store and back to the loading dock. If we take a look at what weapons are out there, which weapons are disproportionately involved in violence, how we are screening the purchasers of guns, whether a felony is adequate criteria to exclude a purchaser or whether any past violent crime should disqualify a purchaser and if we start looking further back, to the point source—the manufacturer—and the design, the wholesaling and retailing of guns, that is where we can make a difference. The gun industry is a legal structure and one that is very amenable to regulation.

They are not going to like it, but we could control gun violence among youth a heck of a lot more effectively there than by blaming a 16 or 17-year-old who wants a gun because he or she is scared and believes the lie that you are safer with a gun than without one. The victims' stories we have heard today indicate that this is anything but the truth.

Mr. TOWNS. Thank you.

Dr. STANTON. I think it is a very interesting question. Unfortunately, I think that I have to agree, that that would probably be the consequence. We have seen so many other examples where minority, particularly urban and especially males, are taking far more than their share of blame for actions that lots more people are involved in.

For example, in Baltimore, over 92 percent of all drug dealing arrests are of minority youths. We know that they are not the only ones. In fact, they are not the ones that are probably reaping the highest percent of the benefits from whatever drug trading is going on.

So while it might have an immediate impact making us feel a bit better—there might be members of society that feel better—I think it basically would be once again hitting that group of people who are already most victimized by violence.

Thank you.

Mr. KELLERMANN. Kids aren't dumb. They are going to do what they think is in their best interests, just like we do. What we have to do is give young people positive alternatives, something better than picking up a gun and robbing a store or knocking somebody off on the street or getting in a fight after school.

We have to give them positive alternatives, and the threat of a felony conviction and jail is not a positive alternative. I think we have to really take a much more long-term view, start with young kids, work with them, give them a better set of choices than the choices they have today.

Mr. TOWNS. We thank both of you.

My final question I think it was for you, Dr. Kellermann, you indicated that we only spent \$20 million on violence in terms of research in 1989.

First, do you know what research is involved and what do you believe our research priorities should be in this area?

I just find that to be a little strange that it is only \$20 million.

Mr. KELLERMANN. That is the best guess. I was a member of the National Research Council panel on the understanding and control of violent behavior which was charged with reviewing the full array of research that has been conducted on violence over the past 10 or 15 years, and I represented medicine and public health on that panel.

That is the best we could come up with and I don't think there has been a real change in the couple of years since that report was issued. That report outlines a number of strategies, as does the Centers for Disease Control report "Healthy People 2000" both contain good recommendations about where we need to go.

That research funded a variety of studies of behavioral and individual correlates of violent behavior, some longitudinal work to look at how kids turn out to be violent when they get older or non-violent when they get older, and a few studies that looked at the relationship between gun availability and violent outcomes.

But \$20 million doesn't go very far when you consider the enormity of the problem and the issues we are having to confront. I think we have to, again, look at a comprehensive long-term strategy that includes both basic research on behavior and applied research on intervention programs, education, enforcement and engineering that can make an impact on violence and evaluate these options rigorously. Then we are going to get somewhere.

It is not going to happen in 1 year or 2, but in 5 or 10 or 15 years, we can have a safer and more secure society than we have today if we are willing to make that investment.

Mr. TOWNS. The use of \$20 million, I tell you, Doc, it doesn't seem to be a serious commitment to the problem when you have the magnitude of the problem we just discussed here this morning. One youngster just indicated in terms of his case, how much was spent on hospital bills, over \$1 million. This is a very serious matter.

It seems to me that a lot more should be allocated for us to come up with some answers. This is destroying families.

As I listen to Mrs. Daly, who indicated the fact that her husband—what it has done to her family. Here is a man providing services to a community, was killed going out looking for a student who had left the school to try to bring the youngster back to the school, which showed his commitment. But at the same time, his life was ended and now the frustration and turmoil and all the problems that his death has created for his family. I just think that when we look at it, we need to make a more serious effort at get-

ting some answers. And \$20 million to me is not a whole lot of money when we have the problem that we have today.

I just think that \$20 million does not show any real commitment on our part.

Mr. KELLERMANN. I couldn't agree with you more, but again, I think it is very important for Congress and the administration and the American public to realize, money spent on violence prevention is a smart investment. This is not another issue where let's just be the Federal Government and throw a bunch of dollars at something. We will get very big financial pay backs in decreased cost at a Federal, State, local and individual level if we begin to invest in violence prevention today.

It is way overdue, but there is no better time to start than now.

Mr. TOWNS. Well, let me thank both of you for your testimony. Let me thank you for the kind of work that you are doing. I just want to say to you that I think your coming here today means a great deal to a lot of people because, as I indicated early on, your entire statement will be included in the record. As people begin to look at this problem of violence, I think that maybe we can make the case that we need to change some things and that our priorities are upside down because we are talking about lives, and that is something that is very, very important.

I think we need to get that message across and thank you for coming and helping us to do so.

Our final panel represents health care providers who treat the victims of violence on a daily basis. I would like to ask Ms. Whitesell; Mr. Alley, who is from a hospital in my district; Dr. Wright; and Mr. Lopez to come to the witness table.

Ms. Whitesell, why don't you begin.

**STATEMENT OF KAREN WHITESELL, CLINICAL SUPERVISOR,
PHYSICAL THERAPY SERVICE, NATIONAL REHABILITATION
HOSPITAL, ON BEHALF OF THE AMERICAN PHYSICAL THER-
APY ASSOCIATION**

Ms. WHITESELL. Mr. Chairman, thank you for inviting me to speak on this important issue. My name is Karen Whitesell and I am a physical therapist at National Rehabilitation Hospital here in DC. I am here on behalf of the American Physical Therapy Association which represents 59,000 health care professionals who evaluate and treat neurological and musculoskeletal dysfunction.

I have spent the last 9 years of my practice working with victims of violent crimes, specifically, gunshot wounds.

Most people, including urban youth, think that one either dies or recovers completely from gunshot wounds. On the contrary, for every one homicide that we read about in the paper, three more are injured and a third of those that are injured are severely injured with brain injuries or spinal cord injuries. In fact, gunshot wounds are the leading cause of brain injury and spinal cord injury in males between the ages of 15 and 28 in urban areas.

Brain injuries cause permanent brain impairment. With a brain injury, you lose the ability to think, to learn, to behave appropriately. You lose control of movement and speech. Some victims of brain injuries are in permanent vegetative states and require 24-hour nursing care.

Spinal cord injuries cause permanent paralysis with an inability to feel and move your arms, body, and legs. There is a loss of bowel and bladder control and some victims are on ventilators in order to breathe. Both brain injuries and spinal cord injuries require extensive hospitalization, rehabilitation, equipment, such as manual and motorized wheelchairs, medical supplies, and medications. Most victims survive their injuries and require these health care services for potentially 40 to 50 years.

A well-known national figure, James Brady, has personally exposed America to the devastating effects of gunshot wounds. His extensive medical and rehabilitative care is testimony to the tremendous physical, mental, and psychological burdens that gunshot wounds place on the individual and the tremendous cost they impose on the health care system. Mr. Brady is an educated individual with health care insurance, with a huge support network, with a supportive employer who will assist in the financial burden of a lifelong injury.

Most victims of violence do not have the advantages that Mr. Brady has. This causes new and great challenges to the health care system.

Most victims have not completed high school and were not employed prior to their injury. This causes vocational retraining and placement to be very difficult. Most victims of violence have very limited, if any, support networks, such as family support to assist them in coping with their disabilities. Therefore, the health care team is usually the primary support network for these patients. This places an enormous psychological burden on the health care providers.

Many times there is no safe environment to which these patients may return when they are ready to leave the hospital. As a result, many receive unnecessarily prolonged hospitalization and treatment until a social worker is able to find placement. Often nursing home placement at enormous cost is required for these youth because there is no one to take them home.

Many victims of violent crime have no health care insurance. Lack of funding may result in health care providers withholding or providing inadequate care or services. This is an enormous ethical burden on the health care providers.

Many victims of violence have a hostile, uncooperative attitude toward health care professionals. This reaction to conflict is the only way many of these individuals know to respond to such a devastating life changing event. They have not led goal-directed lives, nor had hope for control of their futures. Therefore, the health care provider spends more time designing behavioral plans and compliance programs than doing actual physical rehabilitation.

Victims of violence sometimes even threaten the safety of the health care provider.

These victims of violence with brain injuries or spinal cord injuries can potentially live 40 to 50 years with their disabilities. Uninsured or underinsured clients who require multiple extensive hospitalizations, surgeries, therapy, equipment and medication over that period of time place continued stress on the health care system.

In response to the increasing violence in DC, National Rehab Hospital began a trauma prevention program about 5 years ago. Our mission is to educate the area's youth on the devastating effects of brain injury and spinal cord injury. We have made presentations to over 10,000 students.

The most compelling component of our program is a brain injured or spinal cord injured individual describing their personal struggle to the students. This is usually the first time the students have seen someone in a wheelchair and the students are shocked.

Trauma prevention programs are not enough. Legislation has greatly reduced the incidents of motor vehicle accidents causing brain injuries and spinal cord injuries through seat belt and helmet laws. Legislation is needed to reduce brain injury and spinal cord injury from gunshot wounds. To date, there is no cure for spinal cord injury or for brain injuries. The only way to stop this epidemic is to prevent these injuries by attacking the root cause, violent crime.

Thank you.

Mr. TOWNS. Thank you very much, Ms. Whitesell.

[The prepared statement of Ms. Whitesell follows:]



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**Statement
of
Karen Whitesell, PT
for
The American Physical Therapy Association
before the
House Government Operations Committee
Subcommittee on Human Resources and
Intergovernmental Relations
concerning
Violence as a Public Health Issue
November 1, 1993**

My name is Karen Whitesell. I am a clinical supervisor in the Physical Therapy Service at National Rehabilitation Hospital, a comprehensive adult rehabilitation hospital in Washington, D.C. I am here today on behalf of the American Physical Therapy Association (APTA), which represents over 59,000 physical therapists, physical therapist assistants and students.

As a physical therapist in the Washington Metropolitan area for the past nine years, I have witnessed the devastating effects of violence on this area's youth. The rise in violent crimes has also affected my work as a physical therapist and other health care practitioner's practices.

Physical therapists are health care professionals that evaluate and treat musculoskeletal, cardiopulmonary, and neuromuscular dysfunction. We design individualized programs to maximize the patient's physical independence. Physical therapists practice in a variety of settings in which victims of violent crimes are treated. Such arenas include acute care hospitals, inpatient rehabilitation hospitals, outpatient physical therapy facilities, nursing homes, and public school systems. In all of these environments, physical therapists practice in conjunction with other health care providers and share similar effects from treating victims of violence.

Violent crimes, specifically those involving guns, cause devastating physical, cognitive, and psychological disabilities. Two of the most common injuries that result from gunshot wounds are brain injuries and spinal cord injuries. Brain injuries result in the victim having permanent brain impairment affecting his or her ability to think, reason, and behave appropriately. The ability to move one's arms and legs, and to speak and understand speech are permanently impaired. Many victims of gunshot wounds are permanently in vegetative states requiring 24 hour nursing care. Brain injured patients require extensive acute medical care and inpatient and outpatient rehabilitation to stabilize their medical condition, and to attempt to retrain their neuromuscular systems to maximal cognitive and physical function.

Spinal cord injuries caused by gunshot wounds render victims permanently paralyzed, sometimes from the neck down, unable to feel or move their arms, body, or legs. They cannot control their bladder or bowel and must rely on supplies and physical assistance for their most personal daily needs. Some victims depend upon mechanical ventilators in order to breathe. Spinal cord injured individuals require extensive acute care hospitalization to stabilize their medical condition and their spinal fractures. They require inpatient rehabilitation to learn how to perform or direct daily living skills such as bed mobility, wheelchair mobility, dressing, and grooming.

Both brain injured and spinal cord injured victims require extensive durable medical equipment such as power and manual wheelchairs to return to their environment. They require disposable supplies such as catheters for bladder management for the rest of their lives. They may require 24 hour assistance for their daily needs which often translates into nursing home placement.

Both disabilities may render patients unable to gain meaningful employment because of their cognitive deficits, in the case of brain injured victims, and due to their profound physical

deficits, in the case of spinal cord injured victims.

Most people, including urban youth, believe that one either dies from a gunshot wound or survives unharmed. On the contrary, for every one homicide in D.C., three others are wounded, and a third of these are severely injured with brain and spinal cord injuries. Therefore, for every homicide that we read about in the newspaper, there is one youth permanently and severely injured. At National Rehabilitation Hospital, the leading cause of traumatic brain and spinal cord injury in males 15-24 is gunshot wounds. Gunshot wounds now surpass motor vehicle accidents nationally as the leading cause of traumatic brain and spinal cord injuries in urban areas.

A well known national figure, Jim Brady, has personally exposed America to the devastating effects of gunshot wounds. His widely publicized extensive medial and rehabilitative care, some of which was performed at National Rehabilitation Hospital, is testimony to the tremendous physical, mental, and psychological burdens gunshot wounds place on the individual and the tremendous cost they impose on the health care system. Mr. Brady is an educated individual with health care insurance, a huge support network, and a supportive employer, who will assist in the financial burden of a lifelong injury. One can only imagine someone in Mr. Brady's physical and mental situation without these "advantages." Most of the victims of violence do not have these "advantages."

The rise in injuries from violence poses enormous new challenges for health care providers. Victims of violence tend to be young, black males between the ages of 15 and 28. These victims have typically not completed high school, and were not gainfully employed at the time of the injury. Vocational retraining is very difficult in these circumstances. These youth have very limited, if any, support networks to assist them in coping with their disabilities, planning for the future, and meeting their daily living needs. Therefore, the health care team is usually the primary support network for these patients, placing an enormous psychological burden on each health care provider.

Many times, there is no safe environment to which these patients may return when they are medically and functionally ready to leave the hospital. As a result, many receive unnecessarily prolonged hospitalization and treatment from the health care team, until a social worker is finally able to find adequate placement. Often, these young, relatively healthy youth are placed in nursing homes requiring maximal physical assistance, constant supervision, and daily medical intervention to prevent life threatening, costly complications.

Many victims of violent crimes have no health care insurance and obviously cannot afford the enormous bills for hospital stays, durable medical equipment such as wheelchairs, and disposable medical supplies (such as catheters). The lifelong medications that are required are extremely costly too. Lack of funding may result in health care providers prescribing or providing inferior products or services. Withholding care or services or providing inadequate care is an enormous ethical burden on health care providers.

Many brain injured and spinal cord injured individuals, injured by gunshot wounds, have a hostile, uncooperative attitude toward the health care professionals working with them. This reaction to conflict is the only way many of these individuals know to respond to such devastating life-changing injuries. Many victims of violence have not led goal-directed lives nor had hope for the future prior to their injuries, and therefore, cannot understand the rewards of hard work and cooperation, as now the future looks even bleaker. Certainly, their chances of employment are considerably worse after their injuries. Also, many of these victims felt little control over their futures prior to their injuries, and therefore, cannot understand the rewards of hard work and cooperation, as now the future looks even bleaker. Certainly, their chances of employment are considerably worse after their injury. Also, many of these victims felt little control over their futures prior to their injuries, and now, they have much less control over even the simplest of life's tasks. This lack of control is transferred to the health care provider in the form of hostility, manipulation, and non-compliance. Frequently, the health care team spends more time designing behavioral plans and compliance programs than performing actual physical rehabilitation.

Victims of violence often threaten to harm the health care professionals who treat them. An individual responsible for a gunshot wound may continue to threaten the patient, which places the staff in a dangerous situation as well. Under normal hospital policy, the hospital could discharge a patient for threatening staff, but since the patient is so severely physically or cognitively impaired, there is no safe environment to which to discharge the patient that could meet the patient's needs. Therefore, the staff must work under difficult and unsafe conditions.

These patients who have sustained brain and spinal cord injuries from gunshot wounds typically survive their injuries, and can have a normal life span. Therefore, these patients require lifelong health care for secondary complications such as skin breakdown/pressure sores, respiratory complications, bladder infections, cardio-vascular disease, and orthopedic problems. They require replacement wheelchairs, lifelong supplies and medications. Uninsured or underinsured clients who require multiple, extensive hospitalizations, surgeries, therapy, equipment, and medications over a period of perhaps 40-50 years will place continued stress on the health care system.

National Rehabilitation Hospital began a trauma prevention program five years ago in response to increasing violence in the Washington Metropolitan area. Our mission is to educate the area's youth on the devastating effects of brain and spinal cord injuries and the preventable causes of these injuries. We have made presentations to over 10,000 students. The most powerful component of a school presentation is the candid, often shocking account of a brain or spinal cord injured individual's personal struggle with a life changing injury. For many youth, this is the first time they have seen someone in a wheelchair. Hearing and seeing spinal cord injured individuals describe how they now must have help for bladder and bowel care, and cannot feel or move their arms or legs, demonstrates the effects of these injuries in a dramatic way. The students hear from this injured individual that drugs aren't worth the ultimate sacrifice of physical and mental control.

National Rehabilitation Hospital's trauma prevention program has offered and conducted tours of our rehabilitation hospital in addition to the school presentations. The purpose of the tours is to expose youth to the realities of brain and spinal cord injuries and the intensive therapy needed after such injuries. We have also begun visiting area juvenile detention centers to expose these troubled youth on the effects of violent action.

Enactment of seat belt and helmet laws has greatly reduced the incidence of motor vehicle accidents causing brain and spinal cord injuries. Legislation is needed to reduce the devastation that gunshot wounds cause.

In conclusion, gunshot wounds are now the leading cause of permanent, devastating brain and spinal cord injuries in America's urban areas. These injuries require prolonged hospitalizations, surgeries, extensive physical and mental rehabilitation, and expensive equipment, supplies and medications.

Gunshot wounds place tremendous burden on physical therapists and other health care providers because the typical victim of violence is uninsured or underinsured, has relatively little prior education or employment experience, and lacks support systems for emotional, financial, and physical assistance after the injury. Violent, non-goal directed behavior exhibited prior to the injury is often perpetuated and directed to the health care provider after the injury.

There is no cure for brain and spinal cord injuries. The only way to stop this devastating epidemic is to prevent these injuries by attacking the root cause-- violent crime.

Mr. TOWNS. Mr. Lopez.

STATEMENT OF HOMER CHARLES LOPEZ, PSYCHIATRIC SOCIAL WORKER, AND DIRECTOR OF PREVENTION SERVICES, BUREAU OF SUBSTANCE ABUSE SERVICES, FORMER PROJECT DIRECTOR, ADOLESCENT VIOLENCE PREVENTION PROJECT, MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, REPRESENTING THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Mr. LOPEZ. Thank you, Mr. Chairman.

At this time I would formally request to submit my written testimony into the public document and use the remaining portion of my time to summarize my testimony.

Mr. TOWNS. Without objection, the entire statement will be included in the record and you can summarize.

Mr. LOPEZ. Thank you.

First off, I would like to thank you for the opportunity to testify before the Human Resources and Intergovernmental Relations Subcommittee on the critical issue of violence.

My name is Homer Charles Lopez. I am the director of prevention services for the Bureau of Substance Abuse Services for the Massachusetts Department of Public Health. Previously I served the State of Massachusetts as the project director of the adolescent violence prevention project. Today, I am here as a psychiatric social worker to represent the National Association of Social Workers, which currently has over 145,000 members throughout the United States and abroad and is the largest association of professional social workers in the world.

Mr. Chairman, because you are a social worker, you know that we are uniquely positioned to respond effectively to the problems associated with violence, particularly as it affects youth, as it affects families, and victims. Social workers provide the largest percentage of mental health services in the United States.

In addition, the basic social work tenets of respect for cultural values, empowerment of individuals, and attention to nonviolent ways of dealing with conflict and an understanding of how social policies can affect the behaviors of individuals make social workers a vital participant in the public discourse on violence prevention.

As you proceed in the hearing to articulate the components of mental health services for health care reform initiative, you have heard from testimonies today how violence has impacted young people and how violence has impacted victims and families. We are all in this together: social workers, psychiatrists, psychologists, physical therapists, policemen, the Department of Justice, and the Department of Housing.

We all know the consequences of violence and we are now beginning to see how then violence prevention can begin to turn the tide back.

In that course, I then would advocate in recommending to you, sir, as a linkage in the creation of a basic infrastructure that will begin to coordinate, plan and implement violence prevention strategies among all the interdepartmental agencies.

As you know, those agencies and organizations in the community on the front lines, schools, churches, universities, community-based

organizations, family agencies, are all in this process of integrating or participating in some component of violence prevention, providing young people with an opportunity, some alternatives, some choices, but this is not enough.

We have to be critically linked as primary preventionists into mental health services to begin then to offer young people an alternative in so much as in having an opportunity to see somebody who gives respect, see and have an opportunity to talk to somebody who cares. This will be the secondary primary prevention initiative.

Linkage with primary and secondary initiatives will begin then to articulate a foundation of services of information and referral for young people, families, groups and individuals. Together with this, what is critically needed also is a recommendation in training and technical assistance to all those organizations on the front line to begin to move, as Dr. Kellermann was articulating, the research and evaluation components within their programs. They begin to utilize those strategies in building a comprehensive continuum of care.

So primary, secondary preventionists would then have alternatives to treatment. So primary, secondary and tertiary levels of prevention will then have a continuum of care that is critically needed in this health care reform. Treatment around substance abuse medically will offer the opportunity to get it straight and then get out.

Within any health care reform initiative, what is vitally needed is universal access, universal access to these health care services on the same terms and conditions that will exist for physical health care. Also, I would recommend to ensure Federal—strong Federal and continued commitment to mental health care through adequate funding for the Center for Mental Health Services, Substance Abuse Services, Mental Health Services Administration and the Program Center of Ministers.

Linked with these services of course will be the public health initiatives, DOE initiatives, Department of Justice initiatives, all working together on a strategic plan providing a continuum of care that was previously articulated.

We have also recommended that the linkages among mental illness—that we establish linkages among mental illness, chemical dependency and other physical illnesses and public policy decision-making, establish intersystem linkages with other public programs such as those articulated or related to education, employment, housing and the justice system that will critically affect the individuals with mental health disorders and lead to a more—and give opportunity for young individuals and families to have an opportunity to gain care.

As previously articulated in some of the previous testimony, the advice articulated was made around what can we do as public—or as preventionists or mental health preventionists in this system. What was articulated was more handgun control, violence prevention in schools, parent education, early childhood education, comprehensive health education in schools and job training for young people.

All of these recommendations are very important elements and components of prevention, but basic, basic foundation is articula-

tion of respect and equity in putting that back into young people's conversations. Respect for relationships, respect for people's cultural differences and then mediation, conflict resolution, components of violence prevention then can begin to take a foothold in young people and families and parent's lives.

These are all critical recommendations, Mr. Chairman, and I would respectfully then offer myself for more questions.

Thank you.

Mr. TOWNS. Thank you very much, Mr. Lopez.

[The prepared statement of Mr. Lopez follows:]



OFFICE OF GOVERNMENT RELATIONS

National Association of Social Workers

Ann A. Abbott, PhD, ACSW, *President* • Sheldon R. Goldstein, ACSW, LISW, *Executive Director*

THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

Testimony on "Violence As a Health and Mental Issue"

Before the

**Committee on Government Operations
Subcommittee on Human Resources and
Intergovernmental Relations**

of the

U.S. House of Representatives

Presented by:

**Homer Charles Lopez, MSW
Director of Prevention Services for
the Bureau of Substance Abuse
Services for the Massachusetts
Department of Public Health**

**November 1, 1993
Washington, DC**

Introduction

Good Afternoon. Thank you for the opportunity to testify before the Human Resources and Intergovernmental Relations Subcommittee on the critical issue of violence.

I am Homer Charles Lopez, Director of Prevention Services for the Bureau of Substance Abuse Services for the Massachusetts Department of Public Health. Previously, I served the State of Massachusetts as the Project Director for the Adolescent Violence Prevention Project. Today, however, I am here as a Psychiatric Social Worker to represent the National Association of Social Workers (NASW), which currently has over 145,000 members throughout the United States and abroad, and is the largest association of professional social workers in the world.

Mr. Chairman, because you are a social worker, you know that we are uniquely positioned to respond effectively to problems associated with violence particularly as it affects youth, families, and victims. Social workers provide the largest percentage of the mental health services in the United States.¹ In addition, the basic social work tenets of respect for cultural values, empowerment of individuals, attention to non-violent ways of dealing with conflict, and an understanding of how social policies can affect the behavior of individuals, make social workers a vital participant in the public discourse on the violence epidemic.

It is for these reasons and more, Mr. Chairman, that I am especially enthusiastic and optimistic about the meeting of our profession, this week in Orlando, Florida. As I sit before you today, hundreds of social workers across the country, who share the concern of this committee on the spiraling increases in violence are enroute to Florida. Many will participate in an interactive assembly of professionals: "A SPECIAL ASSEMBLY ON VIOLENCE--ITS CAUSES, PREVENTION AND EARLY INTERVENTION," for which NIMH is providing support. The objectives of the Assembly will be to ensure that participants will:

- Discuss and disseminate important findings from research and practice about violence
- Develop responsive strategies that practitioners can implement in their practice settings
- Generate an on-going policy, research, and practice agenda to spur creative solutions to the problems associated with violence
- Raise public awareness of causes and constructive approaches to dealing with violence
- Produce a plan to educate the social work profession and others about approaches to dealing with violence and its aftermath

Presenters representing a variety of disciplines will address the prevalence and correlates of violent behavior; risk factors associated with violence; issues that influence the course of violent versus nonviolent behaviors; immediate and long-term mental health consequences of victimization on the individual, family, and community; and models and/or methods that promote the prevention, early intervention, treatment, and management of violent or abusive behaviors.

Social workers who work with families and individuals of every age in homes, clinics, hospitals, schools, child welfare agencies, substance treatment programs, courts, jails, and a host of other community, state, and federal settings will participate in the Assembly. In these settings, social workers perform as therapists, advocates, educators, managers, administrators, researchers, and policy educators, managers, administrators, researchers, and policy makers. Therefore, social workers have considerable experience and knowledge to share.

I trust that the Committee joins me in looking forward to the information that will be generated by this unique and timely Assembly. In addition, Mr. Chairman, NASW applauds the Subcommittee on Human Resources and Intergovernmental Relations for holding this important hearing and we look forward to sharing information from the Assembly with you and to working with Congress and the Administration to find real solutions to the cycle of rampant violence that plagues our society.

Background

For the purpose of my testimony, I will use the definition of violence found in the *Social Work Dictionary*. "Violence is the severe and intense exercise of force and power, usually resulting in injury or destruction." From this perspective, violence includes not only physical and emotional abuse, (e.g. spouse/partner abuse, suicide, child maltreatment, elder abuse, murder, robbery, and sexual assault) but also the policies or practices that severely interfere with the development of individual potential (e.g. chronic poverty and the "isms" related to race, gender, and sexual orientation, etc.). *It is this definition of violence that requires social workers and others to agree that violence is not a single entity for which there is a single cause or a single cure. My message, therefore, to the Committee is that each type of violence needs its own specific remedy and each remedy should include access to appropriate mental health care services for victims and perpetrators.*

The need for mental health care services has never been more critical. Twenty-four percent of U.S. households are touched by crime annually and 83 percent of U.S. households will be victimized by crime at some point in time.² Although the crime rate per 100,000 people in the United States declined between 1980 and 1984, it rose 10.3 percent between 1985 and 1989.³ This increase was almost uniform around the country. For example, between 1988 and 1989 alone, violent crime increased by 13 percent in the Midwest.⁴ Homicide is the 11th leading cause of death in the United States and interpersonal violence results in serious injuries to enormous numbers of people. Between 1970 and 1986, more than 2.2 million people suffered injuries from the violent behavior of others.

In this country, women and young people are at particular risk. In 1991, there were one million documented incidents of violence perpetrated against women by husbands or partners and an estimated additional three million attacks that went unreported.^{8/} It is estimated that between 21 and 30 percent of all women in the United States have been beaten by a partner at least once.^{9/} (7) It is my sincere hope that Congress moves quickly to pass the Violence Against Women Act which will go a long way toward protecting women on the streets, in their homes, on college campuses and in the courts.

The outlook for young people in America is particularly devastating. Violence and abuse against young people constitutes one of the most serious public health problems in the nation. In 1991, the National Commission on Children reported in *Beyond Rhetoric* that, "young children dodge bullets in their playgrounds and are the easy daily fare of many city streets..."^{7/} Consider these facts:

- The Center for Disease Control estimates that 645,000 high school students (one in twenty) have carried a gun at least once in the past month.^{8/}
- According to the National Education Association (NEA), more than 280,000 students are physically attacked in U.S. secondary schools each month.^{9/}
- Homicide is the leading cause of death among male and female African-Americans between the ages of 15 and 34 years.^{10/}
- Youths between the ages of 16 and 19 have the highest rates of victimization for rape, robbery, and assault and most of these are victims of assailants from their own age group.^{11/}
- Adolescents are the most frequent victims of abuse and neglect, with an incidence of 25.7 cases per 1,000.^{12/}
- In 1989, 2.4 million reports of suspected child maltreatment were filed and more than 900,000 of these cases substantiated.^{13/}

A particularly chilling fact of life for many children in this country is that even when they have escaped actual physical harm, they are frequently witnesses of violence. In a study of fifth-graders in New Orleans, more than half had been victims of violence; more than 90 percent had observed some form of violence; nearly 40 percent had viewed dead bodies; and more than 70 percent had seen weapons used.^{14/} Summarizing the reality of life for many of today's youth, Clementine Barfield, Executive Director of Save of Sons and Daughters (Detroit, MI) wrote that "National statistics don't capture the level of homicide in communities like Detroit or Washington, D.C. Many of our children simply do not make it out of the neighborhood."^{15/}

Mr. Chairman, few people in America would ask the question "Where Is Violence?" We know that it is everywhere. Violence is in our homes; on the streets; in schools; in workplaces; on the highways; in jails; and in the media. Consequently, as the problems associated with violence

increase, the resources spent on dealing with its aftermath also increase and it becomes even more difficult to fight the root causes and nearly impossible to establish preventative initiatives.

Poverty and Other Conditions That Contribute to Violence

Although poverty is not a direct cause of violence, it is one of the strongest single predictors of abuse behavior.^{16/} Poverty and the conditions that contribute to its continuation provide a fertile ground for the seeds of violence.

In 1990, 19.5 percent of the nation's children were living in poverty.^{17/} Poor children are much less likely than their peers from homes with adequate incomes to receive important basics such as adequate nutrition, decent medical care, a safe and secure environment, and early childhood development programs to supplement learning opportunities at home.^{18/} Children born into poverty, without benefit of intervention or a sense of hope or opportunity, are likely to remain caught in the cycle of poverty.

Factors that directly affect poverty rates include education, health care, and housing. Only 80 percent of our young people graduate from high school.^{19/} Poor teenagers, regardless of race, are nearly three times more likely to drop out of school than non-poor teenagers.^{20/} At least 31 million Americans have limited or no access to basic health care services. Nightly, approximately 740,000 persons are without homes^{21/} and experts estimate that almost two million children experience homelessness every year.^{22/} The U.S. Conference of Mayors 1991) stated that 35 percent of the homeless population are families with children.^{23/} All of these factors contribute to the stress and frustration that find expression in violent acts.

In a special edition of the *American Behavioral Scientist* devoted to the impact of poverty on children, Gelles reports data which indicate that although violence towards children occurs in families across income categories, abusive violence is more likely to occur in poor families.^{24/} A study by Whipple found that physically abusive families were significantly more disadvantaged socio-economically than non-abusive families.^{25/} (38) Certainly, the literature about youth gangs speaks to the stressful, disadvantaged background of most gang members.^{26/}

In summary, although the relationship between causative and predisposing factors and the occurrence of violence is complex, experts identify poverty and its associated problems as closely and clearly associated with the incidence of violence.

Anger Generated by Unequal Treatment

For people of color, decades of discrimination translate to inequality with the caucasian majority in terms of employment, income, educational attainment, and health status. For many, the experience of racism and discrimination is so prevalent that they view the country as two separate, hostile, and unequal nations. Review of population demographics published by the U.S. Department of Justice (1991) document that members of the dominant ethnic minority groups

(e.g., African Americans, Hispanic, Native Americans, and Asian Americans) are more likely than non-minority group members to experience social and economic risk factors (e.g., high density population, poverty) for violent victimization.²⁷ For all women, the single greatest danger is assault by husbands or male partners.²⁸ In addition, hate crimes rooted in individuals' learned prejudices, fears, and hatred against particular groups are growing. For example, in 1990, hate crimes against gay men and lesbians increased 31 percent, with the number of murders due to hate crimes doubling.²⁹

In summary, the literature contains a large number of descriptions of violence associated with, and in response to, the various injustices that American culture and society visits upon various minority groups.

Substance Abuse

Alcohol and drug use are linked to violence because alcohol and drugs "disinhibit" individuals and often precipitate responses to stress that otherwise would be unacceptable. Research has found that between 54 and 83 percent of males tested positive for drugs at the time of their arrest.³⁰ Further, drug trafficking is tied to the alarming increase in the shootings on city streets that kill innocent bystanders as well as those involved in the drug transactions. The Office for Substance Abuse Prevention found that alcohol was present in approximately 60 percent of homicides.³¹ More than 70 percent of murders in Washington, D.C. in 1989 were drug related.³²

Clearly, the association between substance abuse and violence is strong and therefore, so is the relationship between substance abuse and violent crime (i.e., crime that is processed by the criminal justice system). Reviews of research in this area suggest that the higher prevalence and higher rate of crime appear to be associated with frequent use of heroin and/or cocaine.³³

Individual Mobility and Changing Family Composition

Among the many de-stabilizing factors affecting society is the extent to which individuals move around the country, particularly in search of employment. Without the support of extended family and familiar ties within a community, individuals are vulnerable to many of the risk factors associated with violence.³⁴ The parenting ability of parents, preoccupied with survival and without extended-family and community ties, often are compromised. Subsequently, one of the common characteristics associated with high-risk youth is the lack of sufficient bonding to parents, and/or having parents who do not monitor, supervise, offer guidance, or communicate with their children.³⁵

In addition, there have been significant changes in recent decades in family composition. The increase in single-parent families, most of which are headed by women, has been dramatic. There is also the issue of the disproportionate number of female-headed, single parent families that are also poor families. Poverty and economic instability are associated with well-documented negative effects on children; often creating a world in which children grow up afraid and ashamed of where they live and where they learn basic survival skills before they learn to

read.^{36/}

Other Serious Stresses

Parental stress has been found to be a significant factor in physical child abuse.^{37/} Whipple found that abusive mothers reported high levels of stress associated with many life events and experienced high rates of depression, dissatisfaction with marriage, and social isolation.^{38/}

Interventions: Research and Demonstrations

In addition to describing the causes of violence, researchers have paid considerable attention to interventions designed to prevent its occurrence or mitigate its effects on victims.

The literature focuses on interventions to alleviate the effects of violence on its victims and interventions to diminish the likelihood that the perpetrators will commit violence again. In terms of victims, the literature about battered spouses suggests that serving women who abuse their children and their children in "safe homes" for periods of up to three months is useful.^{39/} Further, it appears that children exposed to violence can be effectively treated in group settings. This is particularly so when the intervention alters learning that has taken place when the children witnessed violence and helps to ensure that they do not become abusers as adults.^{40/} Especially effective are group programs that focus on children's acquisition of safety skills, ability to label feelings, deal with anger, enlarge and use sources of social support, develop social competence and positive self-concepts, and determine responsibility for violence.^{41/42/43/}

In addition, some practitioners found that inviting children to discuss their experiences in the presence of their parents is effective.^{44/} Finally, group work was found to be a successful strategy to help children cope with the violent death of a classmate.^{45/}

Although there is no consistent profile of a batterer or documentation that programs to help the batterer manage stress and anger, improve communication and self-esteem, and change beliefs are effective.^{46/} On the other hand, group work built on a strategy starting with a commitment to nonviolence and ending up with marital or family therapy has been found useful.^{47/}

In summary, the data about preventive and ameliorative interventions with the victims and perpetrators of violence indicated that carefully tailored approaches that take into consideration the etiology of violence in the population under consideration may be effective on a short and long-term basis. However, much more targeted research, particularly that which rigorously evaluates outcomes, is essential.

Mental Health Care Needs in the Present Health Care System

There is little doubt that the violence which has traumatized so many communities in our society has also increased the need for mental health care services.

Mental illness is a growing problem among American families. Recent data from the National Institute of Mental Health (NIMH) and the National Center for Health Statistics show that 52.4 million adults will suffer from a mental disorder or substance abuse problem at some time in their lives. According to a comprehensive study conducted by NIMH in 1985, one in five adults is faced with a mental disorder in the course of a year. The prevalence of emotional or mental health problems in children is also alarming. The Office of Technology Assessment (OTA) recently reported that approximately 12 percent or 7.5 million of the nation's children and adolescents suffer from an emotional or mental disorder.

Many people who need treatment for a mental disorder do not receive it. According to NIMH, only 18 percent of those adults who have mental disorders receive any type of specialized treatment. OTA estimates that fewer than one in five children who need mental health care services receive appropriate care. Many seek treatment from a general medical care practitioner, rather than from a trained mental health care practitioner. Many more neither seek nor receive the care they need.

Access to care for mental health problems is far more restrictive than access to care for physical health conditions. In today's insurance systems, maximum benefits are lower, deductibles and coinsurance are higher, and the percent of costs reimbursed is substantially smaller for mental health coverage than for physical health care coverage. Additionally, many insurance plans limit lifetime coverage for mental illness, and the annual out-of-pocket costs limits that are typical for medical care insurance often do not apply to outpatient mental health care coverage. To further compound the problem, individuals with a history of mental illness are often denied health insurance through a preexisting condition clause, thus restricting their access to both physical and mental health care coverage. NASW is eager to work with Congress and the Administration as they debate health care reform and we recommend that the following be included in new directions for mental health.

NASW Recommendations for Mental Health

Any health care reform initiative should assure access to a full continuum of appropriate mental health care services on the same terms and conditions that exist for physical health care services. A continuum of mental health services should include prevention, outreach, emergency care (including crisis intervention), case management, inpatient care, and outpatient care (including partial hospitalization, psychotherapy and counseling, rehabilitation, day treatment, family support, and prescriptive medication).

- Within any health care reform initiative, assure universal access to appropriate mental health care services on the same terms and conditions that exist for physical health care.
- Ensure a strong Federal commitment to mental health care delivery through adequate funding of the Center for Mental Health Services (Substance Abuse and Mental Health Services Administration) and programs the Center administers.
- Foster a strong Federal commitment to mental health research that includes attention

to the biological, social, and psychological causes and consequences of mental illness and related conditions and that uses the contributions of researchers who represent the primary mental health care provider disciplines. Services-based research should be an integral component of the Federal research programs.

- Establish linkages among mental illness, chemical dependency, and other physical illnesses in public policy decision-making. Also establish inter-system linkages with other public programs, such as those related to education, employment, housing, the justice system, that critically affect individuals with mental disorders.

Summary

Mr. Chairman, it is true that many among us argue that violence is so deeply rooted in the American psyche that the best hope is to control it, because eradication is beyond the collective American will. However, social workers believe that we can change the fate of our nation if we invest in the concerted efforts of trained and dedicated individuals and groups. These times call for bold policy initiatives and new, cost-effective ways of teaching people to resolve problems without resorting to violence. The following are a few examples of the many programs focused on violence in which social work practitioners are involved:

- Since 1986, Colorado social worker Mike Maday has worked with local school systems to establish conflict resolution programs and schools participating in this innovative program report a 90 percent success rate.^{48/}
- In Urbana, Illinois, social worker Fred Schrupf has worked with a peer mediation program to help settle 500 disputes, 95 percent of which are reported to have remained resolved.^{49/}
- Social worker Karen Panasevich has worked in the Roxbury/Dorchester area in Massachusetts for the last 15 years, specializing in intervention with gang members and multi-problem families.^{50/}
- Dr. Aminifu Richard Harvey works with individuals, families and organizations using Afro-centric approaches to the root causes and treatment of violence in the African-American community.^{51/}

As the professional association for social work, NASW is in an outstanding position to bring the most knowledgeable practitioners, researchers, and policy makers in the country together to train and educate their colleagues and others and to devise new solutions to problems. We are doing just that.

March is National Professional Social Work Month. Each year NASW kicks off a public service campaign during March to help the public understand a national issue of concern. Our theme for 1994 is the link between violence and injustice.

The campaign will inform the American public about the nature of violence in our society. It teaches that the violence we see, for example, gang shootings or child abuse, is only the small tip of the iceberg.

That tip is supported by even more pervasive "institutional violence." An example would be when banks fail to make business loans to minorities, or when job training prepares welfare recipients for only dead-end jobs.

In turn, the "institutional violence" is supported by an entire climate or culture of violence. An example is conventional thinking that passively accepts inequality and deprivation as normal, or attitudes that support notions of group superiority.

Our campaign materials offer "100 Ways To Stop Violence . . . With Justice for All." Each of the 100 activities emphasize things that individuals can do to alter the environment that allows violence to thrive and grow.

NASW will be happy to share their materials with you early in January.

This fall, NASW begins a three-year program funded by US-AID, to examine the relationship between violence and development in third world countries. The program includes:

- Special assemblies on violence at each of its professional annual meetings
- Dissemination of pertinent articles, journals, and other publications
- Promotion of adaptation in the U.S. of innovative programs from other countries known to prevent family violence

The campaign will culminate in 1995 with a nationwide teach-in at schools of social work accompanied by a teleconference which will focus on using development activities both here and abroad as a means of curbing violence.

As NASW continues its work, we would welcome the opportunity to meet with members of this subcommittee to present our findings.

This concludes my testimony and I welcome the opportunity to answer any questions.

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Mr. TOWNS. Dr. Wright.

STATEMENT OF JOSEPH WRIGHT, ASSISTANT MEDICAL DIRECTOR, EMERGENCY TRAUMA CENTER, CHILDREN'S NATIONAL MEDICAL CENTER, WASHINGTON, DC, AND ASSISTANT PROFESSOR OF PEDIATRICS, GEORGE WASHINGTON UNIVERSITY SCHOOL OF MEDICINE AND HEALTH SCIENCES

Dr. WRIGHT. Good afternoon, Mr. Chairman. My name is Dr. Joseph Wright. I am assistant medical director of the emergency medical trauma center at Children's National Medical Center in Washington, DC. I am also an assistant professor of pediatrics at the George Washington University School of Medicine and Health Sciences.

I would like to thank you and the committee members for this opportunity to appear before you today on behalf of Children's Hospital and the countless other health professionals working on the front lines as part of our Nation's emergency medical services system.

Public health nomenclature defines an epidemic as any condition, biologic or social, the occurrence of which is clearly in excess of normal expectancy. Make no mistake about it, violence in America is a public health problem that is raging out of control.

The prime contributor to the carnage on our streets is firearm related violence. Mr. Chairman, over the past 10 years, I have worked in pediatric emergency departments in your home district in Brooklyn, Congressman Payne's district in Newark and here in Washington, DC. I have witnessed firsthand the tremendous toll exacted on our young people by this epidemic of violence.

No matter how many times we hear the numbers, they are still staggering. In America, 200 million firearms including 70 million handguns and 1 million semi automatic weapons. For African-American males, a lifetime probability of being murdered of 1 in 27. Men of color represent the only segment of the population here in the District of Columbia in which life expectancy is actually decreasing.

As an African-American and the father of two young boys, these are very disturbing figures. During the time it will take to conduct this hearing, throughout America, 14 people, including 2 children, will be shot dead. However, mortality statistics don't nearly tell the entire story. They merely represent the tip of the iceberg.

For every childhood death as a result of violent injury, another 40 children are hospitalized and over 1,100 are treated in emergency departments. The economic burden of this morbidity is estimated at \$18 billion annually. As a killer of 30,000 Americans last year, firearm violence has to be treated by health professionals as an infectious scourge the same way that polio and smallpox were a generation ago.

In fact this philosophy has already begun to emerge in the public health community as evidenced by the degree of academic discourse at last week's annual meeting of the American Public Health Association in San Francisco. During the 4-day conference, there were no fewer than 58 different papers, panels and presentations devoted to the scholarly discussion of violence and violence prevention.

The time-tested public health model that has been used effectively to eliminate infectious diseases, promote tobacco and alcohol warning labels and initiate seat belt and bicycle helmet safety legislation must be employed to tackle this monster, a monster that is destroying a generation of young people and threatening the next.

Initiating the public health intervention model must always begin with comprehensive surveillance and tracking systems. Only with detailed information and a complete data base can we learn more about what strategies will be effective and how to implement them. However, we can't limit our efforts to collecting numbers. Broad-based curriculums and violence education and nonviolent conflict resolution must be introduced at the elementary school level and reinforced through integrated programs specifically tailored to the identified needs of the target populations.

Such issues must be community based, culturally sensitive and well funded. Each and every level of government must be prepared to financially support enhanced research in this area. No institutional or programmatic budget should be approved without a line item earmarked for violence prevention.

It will be far more expensive in the long run to continue to pay for escalating levels of trauma care and rehabilitation than to fund programs that will promote behavioral and attitudinal change in our youth and by doing so, become self perpetuating for future generations.

In my remaining few moments, I would like to leave you with an anecdote that haunts me each and every day that I continue to encounter young victims of violence. Just at the end of the last school year, I cared for two young boys who had been shot in a well publicized incident at a public swimming pool. Their injuries were nonlife threatening and after initial trauma assessment and stabilization, I took some time to talk with the youngsters alone. I was struck by the impassivity and mundane nature with which they described their ordeal. It was as if being shot was as ordinary as walking down the street.

With great animation and bravado, they told me about routinely hearing gunshots and witnessing acts of violence in their neighborhood. However, more quietly, they both admitted fearfulness about returning to the community center where the incident had occurred.

It was then that I realized that for many of our youngsters, the issue is not so much the fear of death, but more so the fear of how to continue living.

Once again, Mr. Chairman, I would like to thank you and the other committee members for allowing me this opportunity to share my views and concerns. If I or Children's National Medical Center can be of any assistance to you or your colleagues, please don't hesitate to contact us.

Thank you.

Mr. TOWNS. Thank you very much, Dr. Wright.

[The prepared statement of Dr. Wright follows:]



TESTIMONY PRESENTED TO THE
HUMAN RESOURCES
AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE
HOUSE GOVERNMENT OPERATIONS COMMITTEE
ON
"VIOLENCE AS A PUBLIC HEALTH ISSUE"

MONDAY, NOVEMBER 1, 1993

TESTIMONY PRESENTED BY:
JOSEPH WRIGHT, M.D.
ASSISTANT MEDICAL DIRECTOR,
EMERGENCY TRAUMA CENTER

CHILDREN'S NATIONAL MEDICAL CENTER
111 MICHIGAN AVENUE, N.W.
WASHINGTON, D.C. 20010

Good afternoon, Mr. Chairman. My name is Dr. Joseph Wright. I am Assistant Medical Director of the Emergency Medical Trauma Center at Children's National Medical Center in Washington, DC. I am also an Assistant Professor of Pediatrics at the George Washington University School of Medicine and Health Sciences. I'd like to thank you and the other members of the committee for this opportunity to appear before you today on behalf of Children's Hospital, and the countless other health professionals working on the front lines of our nation's emergency departments.

Over the past ten years I've worked in pediatric emergency departments in Brooklyn, New York, Newark, New Jersey, and Washington, DC and have personally witnessed the tremendous toll exacted on our young people by this epidemic of violence. No matter how many times we hear the numbers they are still staggering:

- Two hundred million firearms in America, including 70 million handguns, and 1 million semi-automatic weapons.
- A 1 in 27 lifetime probability of being murdered for African-American males; as the father of two young boys this is particularly chilling.
- During the course of this hearing, somewhere in America 14 people, including two children, will be shot dead.

However, mortality statistics don't nearly tell the entire story; they merely represent the tip of the iceberg. For every childhood death as a result of violent injury, another 40 children are hospitalized, and over 1100 are treated in emergency departments. The economic burden of this morbidity including rehabilitation and years of productive life lost is estimated at \$14 billion annually.

As a killer of 30,000 Americans last year, firearm violence has to be treated by health professionals as an infectious scourge in the same way that polio and smallpox were a generation ago. In fact, this philosophy has already begun to emerge in the public health community as evidenced by the degree of academic discourse at last week's annual meeting of the American Public Health Association in San Francisco. During the four day conference, there were no fewer than 58 different papers, panels, and presentations devoted to scholarly discussion of violence prevention. The time tested public health model that has been used effectively to eliminate infectious diseases, promote tobacco and alcohol warning labels, and initiate seatbelt and bicycle helmet legislation must be employed to tackle this monster; a monster that is destroying a generation of young people and threatening the next.

In the District of Columbia, as in many of our communities, the incidence of violence among youth continues to be an escalating problem. According to the National Kids Count Data Book, the violent death rate for adolescents is 2.9 times the national average, and has escalated some 363 percent since 1985. Death by firearm is the leading cause of mortality for residents under the age of 20.

For the city's African-American male population, the carnage has contributed to a continually decreasing life expectancy and to a staggering 3,184 years of potential life lost per 100,000 over the last five years. As a point of reference, the average years of potential life lost because of homicide for white males was 273.

Nationwide, inner city emergency rooms are treating three times as many gunshot wounds as they were 6 years ago.

At Children's National Medical Center, the impact of this epidemic of violence has clearly been felt. Admissions for gunshot wounds increased more than 800% between 1986 and 1990. On average about one dozen children present to the Emergency Medical Trauma Center for management of firearms injuries each month.

These patients represent a very small proportion of our 4500 monthly visits, but treating these patients requires and consumes a tremendous level of medical and ancillary service resources.

The public health system (composed of both public and private providers) is being overwhelmed. Children's National Medical Center, for example, is equipped to provide acute care to seriously injured adolescents, but the burden has become such that we have targeted our resources to those patients under the age of 15 -- younger patients are more likely to require the specialized attention at our facility that may not be available at other institutions.

While much of the attention has been given to deaths associated with use of guns, mortality represents just the tip of the iceberg when it comes to examining resource utilization and the emotional burdens born by children and their families.

Between April 1991 and March 1992, the results of an ongoing childhood firearm injury surveillance study of the Nation's Capitol revealed the following:

There were 132 victims of childhood firearm injury.

The victims mean age was 14.7 years.

The actual ages of the victims ranged from 2 months to 19 years.

The mortality rate was approximately 9 percent.

The surgery rate was 22 percent (29 operations).

More disturbing than even these figures, is the fact that 61 percent of these injuries were intentional -- approximately 80 of the victims were injured during the commission of intentional acts of violence.

But not every occurrence of violence is as straightforward as a shooting. Similarly, not every instance of treatment for a victim of violence is reported to the police -- the numbers would be staggering. But providers in our hospital's emergency departments are more and more aware of the possibility that the child on the examination table may require intervention beyond the splint for a broken bone, or surgery and antibiotics for the puncture wound or laceration.

At Children's Hospital, we are keenly aware of the impact of violence -- the impact on the patient and their ability to live a full and productive life, as well as the corrosive effect on the patient's family and the entire community.

Violence within families and among youth in the United States, is an increasingly difficult problem for our communities all across the Nation. Health care providers now recognize they are on the front lines of a burgeoning public health problem. Last year, the number of children who died in the District of Columbia as a result of child abuse doubled. The figures for surrounding jurisdictions showed similar increases. The range of violence to which children and families are exposed, from killings in the street, to coercion and abuse at home, severely limits a child's ability to reach their potential.

In addition to the direct physical and psychological harm caused by violence, including premature death and injury, and years of life lost, these children fail to develop cognitive and literacy skills. Their ability to grow and develop into fully functioning members of our society is too often permanently impaired.

Children's National Medical Center established the first of its kind hospital-based child advocacy program many years ago in an effort to begin to make children whole, and to foster a healthier and more nurturing environment in which to thrive and grow. For example our hospital's Child Protection Division, which employs a multi-disciplinary team of mental health, medical, legal and social work professionals provided services to over 2,000 children last year.

Our approach to the problem of child victimization is one of the many examples of how health care providers can work effectively with the police, the justice, social services and even the school system to better serve our children and our communities.

Effective surveillance and research, however are also a necessity. Only with detailed information and data bases can we learn more about what strategies will be effective and how to implement them. Each and every level of government must be prepared to financially support greater research; no budget should be approved without a line item earmarked for violence prevention. However, we can't limit out efforts to collecting numbers. We must support effective public-private collaboratives which include experienced health care providers as well as our schools in community-based violence prevention and non-violent conflict resolution initiatives specifically tailored to the needs of the individual community.

Again, Mr. Chairman, I want to thank you for allowing me the opportunity to share my views and concerns about these critically important issues. If I or Children's National Medical Center may be of any assistance to you or your colleagues, we will be honored to be called upon.

Mr. TOWNS. At this time I would like to call on Mr. Alley.

STATEMENT OF FREDERICK D. ALLEY, PRESIDENT AND CHIEF EXECUTIVE OFFICER, THE BROOKLYN HOSPITAL CENTER

Mr. ALLEY. Thank you, Chairman Towns. I am Fred Alley, president and chief executive officer of the Brooklyn Hospital Center in Brooklyn, NY. I have been serving the community and the hospital since 1968 and the last 16 years as its president, so I am well acquainted with the very specific details of violence and the hospital.

We are a 650-bed tertiary care, multisite acute care teaching institution, and serve some of the poorest and most medically underserved communities in New York. Diversity of our community, I suppose, can be best characterized by telling you that we have a language bank that is readily utilized by our social work department, our emergency services people and others, of 54 different languages in order to communicate with the people that come and seek refuge at the hospital.

These communities should be very familiar to you, such as Bedford Stuyvesant, Crown Heights, Fort Greene, Bushwick, Williamsburg, Flatbush and others of equal reputation.

The problems those communities face are synonymous with American cities: poverty, unemployment, drug abuse, and violence.

When asked to speak about the effects of violence on the hospital last Monday, I asked for an assessment of emergency room visits that very morning. I learned that of the 105 patients who had arrived since midnight, 10 percent, mostly by ambulances, were the direct result of violence; 7 were still in the emergency room. Three had been admitted to the inpatient service. Still being treated by the way of example were two children involved in violent sexual crimes, one a 16-year-old rape victim and one a sexually abused boy. Both certainly will require significant followup care by our medical and support staff.

A police officer had just come in with a head injury sustained while trying to apprehend a criminal. A young woman, an attempted suicide, was being sutured and treated. A young man, the victim of a violent hit-and-run accident, would most likely be admitted after extensive surgery.

A chronic drug and alcohol abuser had been brought in by the EMS, Emergency Medical Services ambulance with unexplained head trauma. A man who had been shot 2 weeks before came back to have his just-damaged cast around the site of his gunshot wound replaced. He will require extensive followup and possible surgery and rehabilitation in order to restore full function to his injured arm.

This was a typical Monday morning. Friday and Saturday nights are still worse. It is interesting to note that, with the exception of the 16-year-old girl and the police officer, none of these patients had any insurance. It will be up to the hospital to work with them to see if Medicaid benefits or emergency services benefits for coverage can be obtained. Otherwise, they, like 10 percent of the approximate 90,000 emergency room visits that are the direct result of violence in our street and homes, will be without any coverage.

But the financial cost does not end in the emergency room. The vast majority of those who arrive will require admission to the hospital.

In 1992, for example, fully 10 percent of all our inpatient admissions were assigned E-code in the international classification of diseases categories. These are diagnoses which give evidence of external causes of injury. Although these codes include natural disasters, accidental poisonings and the like, it is safe to assume that a large portion of these 2,400 patients in 1992 were victims of violence of some sort.

Let's assume, conservatively, an average cost of \$5,000 per patient, and I am certain that these patients were considerably more complex than our average hospital inpatient admission. It would be a conservative estimate then to say caring for these direct admissions of violence cost the hospital center in excess of \$12½ million in 1992, and this is just for inpatient care. It does not include their followup on rehabilitation, which has been described appropriately earlier.

It is difficult to determine precisely the financial toll this violence exacts on the urban hospital as an essential health care provider, as a safety net, if you will, to the community. From our overstressed emergency room to overcrowding in the 100 percent occupied inpatient beds, other factors occur. It frightens hospital employees, places extreme financial burden and clearly has become the greatest cause of pain and suffering in our cities.

It is instructive to consider why violence has become such an enormous problem in health care. Principal among these has to do with the problem of substance abuse. Certainly, increased drug and alcohol abuse accounts for a significant portion of the overcrowding of today's urban hospital.

In New York City, researchers suggest that as many as 38 percent of all hospital emergencies had some relationship to cocaine abuse. The National Institute for Drug Abuse reports that thousands of additional deaths are caused each year in our cities as a result of violent crimes associated with illicit drug use.

Statistics from the Health Systems Agency of New York City shows that 1.5 percent of all inpatient admissions in northern Brooklyn are directly related to substance abuse.

The impact of drug abuse extends beyond just the user. It becomes the financial problem and the crimes that are perpetrated in order to obtain drugs, to the spouses and the children who are victims of physical and sexual abuse by drug users, to the unborn, and to those hurt by violent crimes while committing and using drugs.

But the chronic drug abuse presages violence for abusers in New York City indicates that 45 percent of those individuals autopsied were found to be cocaine abusers and users and died as a direct result of their violent crime.

However, the cost of drug and alcohol-related violence to the health care system is magnified by the widespread accessibility of handguns. Although the accessibility of handguns does not correlate with increased incidents of violence, illegal handguns do correlate positively with increased severity of injuries sustained as a result of violence in the total number of homicides, and although

mortality across the United States has been declining, death related to handguns has become the second leading cause for death for children.

In northern Brooklyn, the community that I serve in central Brooklyn, homicide has become one of the leading causes of death, and substance abuse is next on that list.

But guns and substance abuse are only two causes of violence in America. The U.S. Justice Department reports that the rate of violent crimes in the United States rose 16 percent during the 1980's. This overall increase has an undeniable, direct and enormous impact on the operations of the urban hospital and ultimately on its financial stability.

Finally, on that Monday morning in our emergency room, a hospital employee was treated for injuries sustained as a result of being struck by violent patients. Unfortunately, this is not uncommon. I have seen in the pediatric service of the hospital a woman attack a nurse. The attacker was an AIDS victim, scratching, spitting in the face of the hospital employee, saying, "I want you to die too."

This last example highlights the direct impact that violence has on hospitals, an impact that goes far beyond the financial. It goes to the very people that are pledging their lives to care for the public health of the community.

The American Hospital Association reports that the number of reported assaults in hospitals increased from 1,435 in 1988 to almost 1,800 in 1989, the most recent years for which statistics are available.

While the majority of these assaults are directed at hospital employees, in cities such as New York, Los Angeles and Chicago, intragang violence has begun to spread to hospitals where rival gang members are being treated.

The cost of in-hospital violence is tremendous to the personnel. According to a survey by the Emergency Nurses Association, members' greatest job-related concern is that of security. While the threat of violence is not limited to urban hospitals, it is particularly problematic in New York City.

Barry Feinstein, president of Teamsters Local 237, which represents security officers, in talking about impact, reported, "In the course of a year, as many as one third of our people will miss work because they have either been shot, knifed, struck with lead pipes, or otherwise physically beaten. The sad truth," he adds, "is that guns as well as other dangerous weapons are in the hospital and are being used."

Hospitals such as the Brooklyn Hospital Center are operating after State and local cutbacks in funding, combined with the most recent decision to reduce Medicare funding even further. They have strained our budget. They have strained our personnel. As the sole provider of care to a medically underserved community, the hospital center is doubly burdened.

In addition, the emergency rooms are already over utilized by poor community members who do not have access to primary care.

The solution—a strong multifaceted solution is necessary to reduce impact. First, we must continue to find and improve our ways that address the problems that create violence much the inner city

poverty, unemployment and substance abuse. I urge you to continue and expand the war on drugs and to pass realistic legislation to reduce the availability and use of illegally obtained weapons that are wreaking havoc on our streets and in our hospitals. But it is most critical that you address these issues within the context of reform of our health care system.

Universal access, primary and preventive care, and rational levels of funding, especially taking cognizance of the attack on the Medicare program. It must become one of your priorities. Hospitals as essential providers are perfectly positioned today to develop primary care outreach centers which we have done, employing people within the community, students and others, to work in an outreach program training, educating and talking through issues in the community. It works.

I have seen it work firsthand, getting the victims to speak to other victims. We must also consider the essential costs associated with, as we transform the system from one that is acute care oriented to primary care.

It does not happen overnight. Safety nets must be established, otherwise more harm can be done than good in my opinion.

And in closing, I thank you, Congressman Towns, for your leadership in developing your letter to the President on behalf of all hospitals in the country and drawing to his attention the essential area of continued Medicare funding.

I will be pleased to answer questions.

Mr. TOWNS. Thank you very much, Mr. Alley, and also let me thank you for the outstanding job that you are doing under very adverse conditions. We appreciate your leadership as well and look forward to working very closely with you to solving some of the problems that we are confronted with.

[The prepared statement of Mr. Alley follows:]

VIOLENCE AS A PUBLIC HEALTH ISSUE

**Testimony before the
Human Resources and Intergovernmental Relations Subcommittee
Committee on Government Operations
United States House of Representatives**

Monday, November 1, 1993

**Frederick D. Alley
President and Chief Executive Officer**

The Brooklyn Hospital Center

TESTIMONY ON "VIOLENCE AS A PUBLIC HEALTH ISSUE"

Human Resources and Intergovernmental Relations Subcommittee
Committee on Government Operations
United States House of Representatives
Monday, November 1, 1993

Frederick D. Alley
President and Chief Executive Officer
The Brooklyn Hospital Center
Brooklyn, New York

Good afternoon. My name is Frederick D. Alley and I am President and Chief Executive Officer of The Brooklyn Hospital Center in Brooklyn, New York. We are a 654-bed, multi-site, acute care teaching hospital which serves some of the poorest and most medically-underserved communities in New York. These communities may well be familiar to you -- Bedford Stuyvesant, Crown Heights, Fort Greene, Bushwick, Williamsburg, and Flatbush. In many ways, these communities have become synonyms for the myriad problems which face American cities. Poverty -- unemployment -- drug abuse -- violence.

When Congressman Towns called last Monday to ask me to speak to you about the effects of violence on hospitals like ours, I learned through an assessment of emergency room visits that Monday morning, that, of the 105 individuals who had arrived in the ER since midnight, 10 percent of patients came to us, mostly by ambulance, with conditions which were the direct result of violent crime. Seven were still in the emergency room. Three had already been admitted to the hospital upstairs.

Still being treated in the emergency room were:

Two children involved in violent sexual crimes: One a 16-year-old rape victim and the other a one-year-old sexually abused boy. Both will most certainly require significant follow-up care, by our medical staff and by the hospital's social service staff.

A police officer who had come in with a head injury sustained while trying to apprehend a criminal.

A young woman who had attempted suicide and was being sutured and treated.

A young man, the victim of a hit-and-run accident, who would most likely be admitted and require extensive surgery.

A chronic drug and alcohol abuser who had been brought in by the emergency medical service ambulance with an unexplained head trauma.

A man who had been shot two weeks before came in to have a damaged cast around the gunshot wound replaced. He will require extensive follow-up care and possibly surgery and rehabilitation services to restore full function to his injured arm.

This was a typical Monday morning. Friday and Saturday nights are worse still. And it is interesting to note that, with the exception of the 16-year old girl and the police officer, none of these patients had insurance to cover the expense of their care. More than 10 percent of the approximately 90,000 emergency room visits that we see are the direct result of violence in our streets and in our homes. But the financial cost does not end in the emergency room. The vast majority of those who arrive in our emergency room will require admission to the hospital -- for extended care, frequently surgery, rehabilitation and the extensive social services they will require.

In 1992 for example, fully 10 percent of all of our hospital's inpatient admissions were assigned E-code in the ICD-9 diagnostic categories. These are diagnoses which give evidence of "external causes of injury." Although E-codes include things like natural disasters, accidental poisoning, and the like, it is probably safe to assume that a large portion of these 2,450 patients in 1992, were victims of violence of some sort. Let us assume that our hospital's average case costs approximately \$5,000, although I am certain that these were considerable more complex cases of injury than our average hospital inpatient, it would be a conservative estimate to say that caring for victims of violence at The Brooklyn Hospital Center in 1992 cost in excess of \$12,500,000. And this is just inpatient care. It does not include the dollars for their initial emergency care, nor for their follow-up and rehabilitation.

While it is extremely difficult to determine precisely the financial toll which violence exacts on the urban hospital, there can be no doubt that the cost is enormous. From over-stressed emergency rooms, to over-crowding in already 100% occupied inpatient units which limits the ability to care for other patients, to frightened hospital employees, to the extraordinary financial burden generated by both traumatic and chronic injuries, violence, in all its forms, has become the greatest cause of pain and suffering in our cities, among the greatest concerns of our employees and one of the greatest causes of the financial crisis we face in delivering health care in the urban environment.

It is instructive to consider the reasons why violence has become such an enormous problem in health care. Principal among these has to be the problem of substance abuse. Certainly, increased drug and alcohol abuse accounts for a significant portion of the overcrowding of today's urban hospital. In New York City, researchers suggest that as many as 38 per cent of all hospital emergencies had some relationship to cocaine abuse. The National Institute for Drug Abuse reports that thousands of additional deaths occur in our cities each year as a result of violent crimes associated with illicit drug use. Statistics from the Health Systems Agency of New York City show that 1.5 percent of all inpatient hospital admissions in the northern Brooklyn communities our hospital serves are directly related to substance abuse.

The impact of widespread drug abuse extends far beyond the user: to victims of crimes perpetrated by the drug user in order to finance his habit; to spouses and children who become victims of physical and sexual abuse by the drug user; to the unborn; to those hurt by violent crimes committed by the drug user while under the influence. But chronic drug abuse presages violence for the abuser as well: in New York City, 45 per cent of those individuals autopsied who were found to be cocaine users died as a direct result of violent crime.

However, the cost of drug and alcohol related violence to the health care system is magnified by the widespread accessibility of handguns. Although the accessibility of handguns does not correlate with increased incidents of violence, illegal handguns do correlate positively with increases in the severity of injuries sustained as a result of violence and in the total number of homicides. And, although mortality across the US has been declining, death related to handguns has become the second leading cause of death for children. In the northern Brooklyn communities we serve, homicide has become one of the leading causes of death and substance abuse is high on the list as well.

But guns and substance abuse are only two causes of violence in America. The US Justice Department reports that the rate for violent crimes in the US rose 16 percent during the 1980s. And this overall increase has had an undeniable, direct and enormous impact on the operations of the urban hospital and ultimately on the financial stability of our health care system.

Finally, on that Monday morning in our emergency room, a hospital employee was treated for injuries sustained as a result of being struck by a violent patient.

This last example highlights the direct impact that violence has on hospitals, an impact that goes beyond the financial to the very personal. The American Hospital Association reports that the number of reported assaults in hospitals increased from 1,435 in 1988 to 1,789 in 1989 (the most recent year for which statistics have been gathered). While the majority of these assaults were directed at hospital employees, in cities such as New York, Los Angeles and Chicago, intra-gang violence has begun to spread to hospitals where rival gang members are being treated.

The costs of in-hospital violence are tremendous on a very personal level. Physicians and nurses are becoming increasingly anxious over the potential for violence in our emergency rooms. According to a survey by the Emergency Nurses Association, members' greatest job-related concern is that of security. While the threat of violence is not limited to urban hospitals, it is particularly problematic in New York City. Barry Feinstein, president of Teamsters Local 237, which represents security officers in many of the city's hospitals, has quantified the impact that in-hospital violence has on hospital security forces. He says, "In the course of year, as many as one-third of our people will miss work because they've either been shot, knifed, struck with lead pipes, or otherwise physically beaten. The sad truth", Feinstein adds, "is that guns as well as other dangerous weapons are in the hospital."

Hospitals such as The Brooklyn Hospital Center are already operating under financial strain. State and local cutbacks in funding, combined with recent federal decisions to reduce Medicare funding, further strain our budget. As the sole provider of care to the medically underserved community of northern and central Brooklyn, the Hospital Center is doubly burdened: while our emergency room sees a disproportionate number of violent crime victims, many of these patients are unable to pay for their care. In addition, emergency room services are already over-utilized by poor community members who do not have access to primary care.

A strong, multi-faceted solution is necessary to reduce the impact of violence on the health care industry. First, I urge you to find ways to address the problems that create the violence, the problems of the inner-city, of poverty, of unemployment, of substance abuse. I urge you to continue the war on drugs and to pass realistic legislation to reduce the availability and use of illegally obtained weapons that are wreaking havoc on our streets and in our hospitals. But it also is critical that you address reform in our health care system. Universal access to health care for all, the encouragement of primary and preventive care programs and rational levels of funding, especially in the Medicare program, must become your priority.



Mr. TOWNS. Let me just sort of raise with all of you in terms of your work and what you are doing and some of the things that you have experienced. As far as coverage under the health care reform bill, what would each of you suggest as the kind of benefits we should cover that are not available to patients you are currently treating or experiences that you have encountered over the past several years in terms of health care delivery? What is there that should be covered that is not covered now?

Dr. WRIGHT. From my vantage points, Mr. Chairman, I would like to advocate——

Mr. TOWNS. Pull another mike up. I think that one is not on. Pull one over. That one is not working.

Dr. WRIGHT. OK.

Mr. TOWNS. Thank you, Dr. Wright.

Dr. WRIGHT. From my vantage point, Mr. Chairman, I would like to personally see universal access for our youth. I think one of the things which leads to high risk youth is the fact that primary and preventive care tails off as children tend to grow out of childhood and move into adolescence.

The youngsters that I treat in our emergency department are usually coming to the attention of health care providers only through acute episodes, injuries, and violent acts. They are not generally part of a primary care system. I think that insuring that these youngsters have access and are part of primary care services in a way that Dr. Stanton described would be what I would like to see as an essential part of any type of health care reform, particularly one which would have a focus on changing behaviors amongst young people.

Mr. TOWNS. Ms. Whitesell.

Ms. WHITESELL. Two things that I would like to see covered are, one, in- and outpatient rehabilitation. With each passing week, the funding for inpatient rehabilitation and outpatient rehab is being cut and this makes it much more difficult for the health care team to get accomplished everything that they need to accomplish prior to sending this person home, such as training the person, training the family or the personal care attendants who will be taking care of these brain injured or spinal cord injured victims.

I think a second thing would be durable medical equipment. Many of our spinal cord patients and brain-injured patients require manual wheelchairs, motorized wheelchairs, sometimes environmental control units, sometimes ventilators, and we have a difficult problem getting these items funded.

Mr. TOWNS. Mr. Alley.

Mr. ALLEY. The primary care and emergency services programs as they are outlined in the reform plan are admirable. They must include a comprehensive nature for the nonhealth related—or the health related but nonmedical doctor, nurse component of health educators, community service individuals and community-based programs that can realistically work and make a difference within the community.

An example of this that is the New York State primary care grant initiative that I can supply you, Chairman Towns, and others with that provides funding in a variety of levels and it is not terribly expensive, but it works because it is at the grassroots.

Second, we have to pay careful attention to undocumented aliens. They get sick, and I know there are provisions within the legislation currently that provide ultimately for a reimbursement mechanism, but they are a very large part of a lot of the inner-city problems and those very people at this point in time are afraid to come to the hospital and—or to the outpatient departments or the community-based programs and register for fear of being—for fear of being found out and deported and we must realize that they are a large part of what we are talking about right here.

Mr. TOWNS. Mr. Lopez.

Mr. LOPEZ. I think, Mr. Chairman, along the same lines, in expansion of that, of the community-based health educator, it is a commitment from the Federal Government to create opportunities for community residents to have equal opportunity to education for health education professions.

Too often is the case in the community do we neglect our natural healers, the tribal healers, the things of that nature, but then there are young people who will look for opportunities in health and health professions who could have an opportunity for some—to a program or contribution back into community service in a health care reform package.

So I think young people would look and do look to health educators who are from the community who then have grown up and know the neighborhood and therefore have already achieved a level of trust and legitimacy because they have taken the time to take their life and put it back into the community, so looking at opportunities to afford that or to create that and make that happen would be beneficial.

Dr. WRIGHT. Mr. Chairman, I would just like to echo what Mr. Lopez has said because in my own education, the only way I was able to go to medical school was through the National Health Service Corps which was functional at the time. It has been resurrected in a reduced form under the current administration.

I was able to go back and practice at a community based center on the corner of Nostrand Avenue and Kosciusko Street, which you know well, and serve the community in which I had grown up. My grandmother lived around the corner and my—the people I grew up with and knew very well were able to drop in at a moment's notice.

So I really have to concur with what Mr. Lopez is saying. Those kinds of opportunities for people from the community to go and become educated and come back to the community need to be enhanced.

Mr. TOWNS. Let me say that I agree with you. I think that we need to do more of that, and maybe we can get to that if we are trying to get doctors into primary care. Maybe that is one way to strengthen the program, and we might be able to attract some. I think that is an interesting point, because as it stands now, with the concept that we are putting forth, we do not have enough primary care physicians, so maybe as we resurrect the program, maybe we can expand it and one route might be to be able to bring some folks in, something to look at at least.

Also, let me just thank all of you for coming because I think that violence is an issue that we really must begin to address in a very

serious way. Dr. Wright, I was happy to hear that you indicated that in the conference in San Francisco, that at least they are beginning to talk about it and that several papers were presented on the subject. I am concerned over the fact that the whole question of violence has not gotten the attention that I feel that it should have received based on information that you just passed along to us in terms of what it is doing to our hospitals and the kind of costs that are involved. Because of medical costs alone, because we are not addressing it, that we must put more money into research.

I hope that we can create a situation where we can target money to begin to deal with the problem. I think that in some areas the problems are somewhat unique, that they are somewhat different and that we need to be in a position to target money to those areas. I am hoping that as a result of hearings like this, that we can begin to make the point that there is a very serious public health problem involving violence that needs to be addressed.

So let me thank all of you very, very much for your testimony, coming and sharing with us. I think that as a result of your statements, that all of us will be able to benefit from your efforts greatly.

Thank you all very much. This hearing is now concluded.

[Whereupon, at 2:07 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]



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